**Allergy & Asthma Care of Western Michigan**
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Welcome to our office! Please tell us about yourself by completing the following questionnaire.

**NAME**_____ **DATE**_____
Date of birth_____ Place of birth_____

- What problems would you like to address at the office visit

_____
_____

- Please list doctors you see regularly (name and specialty; please identify who is your primary care doctor)

_____ _____
_____ _____

- What past medical problems have you had including injuries, surgeries, and hospitalizations

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

- What medications do you take – regularly or as needed – prescription or over the counter

_____ _____ _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

- Do you have adverse reactions, including allergies, to any medications (specify reaction)

_____ _____ _____
_____ _____ _____
_____ _____ _____

- Have you ever had problems with ☐allergic rhinitis (hayfever) ☐asthma ☐atopic dermatitis (allergic eczema) ☐food allergy ☐latex allergy ☐insect sting venom allergy

- Any personal history of the following medical problems (check all those that apply)

| | | | | |
|---|---|---|---|---|
| ☐anemia | ☐heart disease | ☐cataracts | ☐headache | ☐arthritis |
| ☐bleeding disorder | ☐heart murmur | ☐glaucoma | ☐seizures | ☐osteoporosis |
| ☐cancer | ☐heart attack | ☐hepatitis | ☐bronchitis | ☐HIV+ / AIDS |
| ☐blood clot in legs | ☐high blood pressure | ☐liver disease | ☐emphysema | ☐reflux disease |
| ☐blood clot in lungs | ☐high cholesterol | ☐kidney disease | ☐pneumonia | ☐ulcer disease |
| ☐stroke | ☐diabetes | ☐thyroid disease | ☐tuberculosis | ☐other _____ |

## Family History

- Any family history of the following medical problems (check all those that apply)

| | | | | |
|---|---|---|---|---|
| ☐anemia | ☐stroke | ☐diabetes | ☐emphysema | ☐allergic rhinitis/hayfever |
| ☐bleeding disorder | ☐heart attack | ☐seizures | ☐tuberculosis | ☐asthma |
| ☐cancer | ☐high blood pressure | ☐kidney disease | ☐osteoporosis | ☐atopic dermatitis |
| ☐leukemia | ☐high cholesterol | ☐thyroid disease | ☐ulcer disease | ☐food allergy |

- For each family member please note individuals age, if any major medial problems, or if deceased the cause of death. Also, for each please note if any allergy problems. If there are extended relatives with allergy problems please list

Father _____ Mother _____

Siblings_____ _____ _____
_____ _____ _____

Children_____ _____ _____
_____ _____ _____

## Environmental and Social History (please circle as applicable)

- What type of residence — home condo apartment mobile home lake home other _____
- How old is residence _____
- How long have you been at residence _____
- Ever any water damage (yes/no) _____
- How many floors in residence — one floor two floors three floors four floors
- Is there a basement (yes/no) — finished concrete dirt floor cellar
- Is there carpeting (yes/no) — basement first second bedroom
- What floor is bedroom — basement first second third
- What type of mattress — spring waterbed air mattress futon other _____
- Any feather bedding(yes/no) — pillow blanket mattress
- What type of heating — forced air radiator baseboard (electric) wood other _____
- Is there an air conditioner(yes/no) — central room unit window unit
- Is there a humidifier(yes/no) — central room unit
- Is there a de-humidifier(yes/no) — central room unit
- Do you smoke currently(yes/no) — how many packs per day how many years
- Have you smoked in the past(yes/no) — how many packs per day how many years when did you quit
- Anyone else at home smoke(yes/no) — in the home(yes/no) in the car(yes/no) outdoors only
- Alcohol use _____
- Street drug use _____
- Marital status — single married divorced widowed
- Who lives at home _____ _____
- Any pets — animal type / how many / how long

| animal type | how many | how long |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

- Other states/countries you have lived _____
- Any foreign travel(where/when) _____
- Hobbies _____
- Occupation _____
(working/student/homemaker) _____
(if student, what level of school) _____
- Previous occupations _____ _____

## Review of Systems

(circle all that apply)

- General — fever chills night sweats fatigue excess weight gain excess weight loss
- Eyes — visual changes seeing spots redness itching tearing discharge
- Ear, nose, throat — hearing loss ringing in ears blood from nose nasal congestion nasal discharge; post nasal drip sneezing facial pain loss of sense of smell; dental problems teeth grinding jaw pain sore throat hoarseness
- Cardiovascular — chest pain short of breath with exertion short of breath lying flat; heart flutter fainting swelling in feet/ankle
- Respiratory — short of breath chest tightness wheezing cough cough with sputum cough with blood
- Gastrointestinal — nausea vomiting abdominal pain diarrhea constipation; heartburn reflux spitting up/regurgitation difficulty swallowing
- Genitourinary — incontinence frequent urination pain with urination urgency to urinate; blood in urine waking at night to urinate
- Musculoskeletal — joint pain joint tenderness decreased range of motion; muscle pain muscle weakness bone fracture
- Skin — rash eczema hives swelling blistering lumps
- Neurological — headache dizziness seizure unsteady walking tremors/shaking; numbness weakness
- Psychiatric — depression anxiety stress irritable sleep disturbance
- Endocrine — heat intolerance cold intolerance hair changes excessive thirst
- Hematologic — bruising bleeding problems swollen lymph nodes

_____ _____ _____

(Signature) (Date)

**NAME**_____ **DATE**_____
**DOB** _____

## If nasal, sinus, ear, or eye symptoms are a problem, please fill out this section.

- When did the symptoms first begin _____

- How have they progressed over time (constant? intermittent? improving? worsening?)
_____
_____

- What specific nasal symptoms have you noticed (please circle yes or no – underline the symptoms that bother you the most)
  - □(yes/no)nasal congestion
  - □(yes/no)blowing nose regularly or runny nose – if yes, what color material _____
  - □(yes/no)post-nasal drip
  - □(yes/no)sneezing
  - □(yes/no)itching
  - □(yes/no)facial pain/pressure
  - □(yes/no)decreased sense of smell
  - □(yes/no)blood from nose
  - □(yes/no)snoring
  - □(yes/no) mouth breathing

- Do you have eye symptoms (yes/no) (if yes, check all that apply)
  - □itching
  - □redness
  - □swelling
  - □tearing
  - □discharge
  - □wear contacts
  - □history of glaucoma
  - □history of cataracts

- Do you have ear symptoms (yes/no) (if yes, check all that apply)
  - □itching
  - □fullness/pressure
  - □popping
  - □hearing loss
  - □ear infections
  - □ear tubes placed

- How frequent are the symptoms □constant □daily □weekly □monthly □intermittent

- What is the timing of the symptoms □just certain seasons □year round □year round but worse in certain seasons
  Also, please circle the months or seasons that are worse
  January – February – March – April – May – June – July – August – September – October – November – December
  Winter Spring Summer Fall Winter

- Please check any specific triggers that you have noticed
  - □ pollens □dust □molds □animal exposure
  - □ smoke □perfumes □fumes □cleaning products □temperature changes
  - □ alcohol □spicy foods □any eating □airplane trips/flying □weather changes

- Please list any medications used for the nose, ears, or eyes and comment if they helped or not (prescription or over the counter)
_____ _____ _____
_____ _____ _____
_____ _____ _____

- Do you have a history of nasal polyps (yes/no)

- Do you have a history of sinusitis (yes/no)
  If yes, have you been treated with antibiotics (yes/no) □how long on antibiotics □last time on antibiotics
  If yes, have you ever had a sinus X-ray or CAT scan (yes/no) □when was the test □where was it done

- Have you ever seen an ENT doctor (yes/no) □when □where (city, state) □doctor's name
  If yes, have you ever had to have nasal or sinus surgery or have nasal polyps removed □when □procedure □did it help (yes/no)

- Have you had an allergy evaluation in the past (yes/no) □when □where (city, state) □doctor's name
  If yes, what were the results of allergy testing
  If yes, have you ever been on allergy shots (immunotherapy) □did it help (yes/no)

**NAME**_____ **DATE**_____
**DOB** _____

## If breathing or chest symptoms are a problem, please fill out this section.

- When did the symptoms first begin _____
- How have they progressed over time (constant? intermittent? improving? worsening?)

_____
_____

- What specific respiratory symptoms have you noticed (please circle yes or no – underline the symptoms that bother you the most)
  - (yes/no)shortness of breath
  - (yes/no)wheezing
  - (yes/no) chest tightness
  - (yes/no)cough
  - (yes/no) do you have symptoms at night
  - (yes/no) do you have symptoms with exercise
- How frequent are daytime symptoms
  - constant
  - daily
  - < 2 times per week
  - > 2 times per week
  - weekly
  - monthly
  - intermittent
- How frequent are nighttime symptoms
  - nightly
  - weekly
  - monthly
  - intermittent
- What is the timing of the symptoms
  - just certain seasons
  - year round
  - year round but worse in certain seasons

  If certain times are worse, please circle the months or seasons that are worse

  January – February – March – April – May – June – July – August – September – October – November – December

  Winter Spring Summer Fall Winter
- Please check any specific triggers that you have noticed
  - pollens
  - dust
  - molds
  - animal exposure
  - smoke
  - fumes
  - cleaning products
  - cold air
  - temperature changes
  - exercise
  - upper respiratory infections
  - airplane trips/flying
  - weather changes
- Do you have problems with heartburn (gastro-esophageal reflux disease) or ever used medicines for heartburn / reflux (yes/no)
- Do you use any of the following medications regularly
  - beta-blockers
  - aspirin
  - NSAIDs [for example ibuprofen (Advil, Motrin)]
- Please list any medications you have used for breathing and comment if they helped or not (prescription or over the counter)

_____ _____ _____
_____ _____ _____
_____ _____ _____

- If you use a quick relief inhaler (albuterol, ProAir, Proventil, Ventolin) how often have you had to use it in the past month
- If you use inhalers, do you have a spacer device for the inhalers (yes/no)
- Have you ever had to be on prednisone (steroid tablets) (yes/no)
- Do you have a nebulizer machine at home (yes/no)
- Have you ever been told asthma in the past as a diagnosis (yes/no)
  - if no, has it been suspected (yes/no)
- Have you ever had to go to the emergency room (ER) for breathing problems or asthma (yes/no)

  If yes, how many times total or how many times per year
  - where
  - when was last ER visit
- Have you ever had to be hospitalized (stayed over night) for asthma (yes/no)

  If yes, how many times

  If yes, have you ever had to stay in the intensive care unit (ICU) (yes/no)
  - have you ever had to be intubated (yes/no)
- Have you ever had a chest x-ray (yes/no)

  If yes, have you ever had a problem on a chest x-ray

  When was the last chest x-ray
- Have you ever used a peak flow meter (yes/no)

  If yes, what is your usual peak flow reading

**NAME**_____ **DATE**_____
**DOB** _____

## If a skin reaction is a problem, please fill out this section.

- When did the skin reaction first begin _____
- How has the skin reaction progressed over time (constant? intermittent? improving? worsening?)

_____

- What does the skin reaction look like red? raised? itching? lasts hours to days then moves to other area?
  scaling/flaking? lasts days to weeks?
- When there is an outbreak, how long will any individual spot last
- What parts of the body are affected
  ☐face ☐neck ☐chest ☐abdomen ☐back ☐arms ☐legs ☐any
- How often are the reactions, or if it is persistent how long has it been present
- Has there been any associated swelling episodes (yes/no)
  ☐lip ☐tongue ☐throat ☐eyes ☐face ☐hands ☐feet
- Has there been any other associated problems (yes/no)
  ☐dizziness ☐loss of consciousness ☐shortness of breath ☐wheezing
  ☐nausea ☐vomiting ☐abdominal pain ☐diarrhea
- Have the reactions been associated with any particular foods (yes/no)
- Have the reactions been associated with any particular medications (yes/no)
- Have the reactions been associated with the use of aspirin or its relatives called NSAID's (like ibuprofen =Advil, Motrin) (yes/no)
- Has there been any antibiotic use associated with development of the skin reaction (yes/no)
- Have the reactions been associated with exposure to latex (rubber gloves, balloons, etc.) (yes/no)
- Have the reactions been associated with anything coming into contact with the skin (yes/no)
- Have the reactions been associated with physical pressure to the skin (can occur up to 12 hours after the pressure to the skin) (yes/no)
- Have the reactions been associated with sun exposure (yes/no)
- Have the reactions been associated with high temperatures (heat) (yes/no)
- Have the reactions been associated with low temperatures (cold air, or cold foods, or swimming in cold water) (yes/no)
- Is there any history of thyroid disease (yes/no)
- Is there any history of recent infections (yes/no)
- Is there any history of chronic infections (yes/no)
- Has there been any blood work done to look for a possible cause (yes/no) Has there ever been a skin biopsy (yes/no)
- Other doctors you have seen for the skin reaction

_____ _____ _____

- Medications used for the skin reaction, and please comment if a particular medication helped or not

_____ _____ _____
_____ _____ _____