

## ADULT ALLERGY QUESTIONNAIRE

Today's Date:

Patient's Name:

Date of Birth:

Age:

Address:

Phone:

### Primary Care Physician/Pediatrician

Name:

Phone:

Address:

Fax:

**Referring provider**, if different from primary care physician:

Name:

Phone:

Address:

Fax:

### 1. CHIEF COMPLAINT (reason for visit):

### 2. PRIOR ALLERGY EVALUATION AND TREATMENT:

Have you been previously evaluated for allergies? Yes  No

*(If yes, complete this section)*

Have you ever had an allergy skin test? Yes  No

If yes, Date:

Results:

Have you ever had an allergy blood test? Yes  No

If yes, Date:                      Results:

Have you ever received immunotherapy (allergy shots)? Yes  No

If yes, Dates:                      For what allergies?

**3. FOOD REACTIONS:** Yes  No  *(If yes, complete this section)*

Are you on any special diets?                      Avoiding any foods?

If yes, please list in the table below:

<u>Food</u>	<u>Age Avoided</u>	<u>Symptoms</u>	<u>Still Avoiding?</u>

Do you have itching in your mouth after eating raw/fresh fruits or vegetables (i.e. bananas, melons, apples, peaches, pears, kiwi, citrus, tomato, potato), shellfish, peanut, or tree nuts? Yes  No

If yes, please list specific food triggers and age of onset:

**4. ASTHMA HISTORY:** Yes  No  *(If yes, complete this section)*

Age of onset:                      Frequency of attacks:                      Most recent exacerbation:

**Have you ever needed any of the following for asthma? (Please answer with the most recent first.)**

Hospital admissions:

Emergency room visits:

ICU admissions:

Intubations:

**Symptoms:** Wheeze  Cough  Sputum  Exercise Intolerance   
Chest Pain  Shortness of breath

**Night time cough:** Yes  No

**Season worse in:** Winter  Spring  Summer  Fall

**Triggers:**

**5. ALLERGY & ASTHMA TRIGGERS: (Please select choices, check "Yes" or "No", and list symptoms)**

	<u>Yes</u>	<u>No</u>	<u>Symptoms</u>
Grass exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Tree exposure	<input type="checkbox"/>	<input type="checkbox"/>	
Raking leaves <input type="checkbox"/> Mowing lawn <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Damp areas with mold and mildew	<input type="checkbox"/>	<input type="checkbox"/>	
Sweeping <input type="checkbox"/> Dusting <input type="checkbox"/> Vacuuming <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Smog <input type="checkbox"/> Air Pollution <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Temperature changes (hot <input type="checkbox"/> cold <input type="checkbox"/> )	<input type="checkbox"/>	<input type="checkbox"/>	
Tobacco smoke	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	



- Animals (cats, dogs, etc...)
- Coughing after drinking cold or hot water
- Colds (Virals URI's)
- Cleaning agents, fumes, perfumes
- Others:

**6. INSECT ALLERGY: Yes  No  (If yes, complete this section)**

**Insect:** Unknown  Honeybee  Yellow jacket  Wasp  Hornet  Fire ant

**Symptoms:**

- Local swelling  Generalized swelling  Hives
- Pain  Wheezing  Shortness of breath
- Throat tightening  Difficulty swallowing  Loss of consciousness

**7. LATEX ALLERGY: Yes  No  (If yes, complete this section)**

Date                      Source                      Reaction

**8. MEDICATIONS**

Please list **ALL medications**, including any **herbal or alternative medications**, that you are **currently taking (including dosage and frequency)**:

Have you ever used the following medications:

- Nasal Sprays:**  Rhinocort  Flonase  Nasonex  Nasacort  Veramyst  
 Astelin  Afrin  Other:

**If yes, when, and at what dose & frequency?**

**Inhalers:**  Proventil/Albuterol  Xopenex  Flovent  Pulmicort  Qvar  
 Advair  Inhaled cromolyn  Theophylline  Other:

If **yes**, when, and at what dose & frequency?

Last time used:

**9. MEDICATION/DRUG REACTIONS:** Yes  No  *(If yes, complete this section)*

<u>Date</u>	<u>Drug</u>	<u>Reaction</u>	<u>Taken Since</u>
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**10. HISTORY OF REPEATED INFECTIONS:** Yes  No  *(If yes, complete this section)*

<u>Type</u>	<u>Date</u>	<u>Antibiotic needed</u>	<u>Abnormal tests (i.e. Chest X-rays/ CT Scans/Blood tests)</u>
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Ear Infections

Sinusitis

Pneumonia

Bronchitis

Meningitis

Dental Infections

Bladder/Kidney Infections

Skin Infections

Joint Infections

Gastrointestinal Infections

**11. OTHER MEDICAL/SURGICAL HISTORY: (Please answer all items)**

- A. List other medical illnesses:
- B. Any surgeries:
- C. Any ER visits/hospitalizations? For respiratory or allergic reactions? When?

What treatment did you receive?

- D. For women, are your menstrual periods regular? Yes  No

Number of days in typical cycle:

**12. IMMUNIZATIONS:**

- A. Are your immunizations up to date? Yes  No  **If no, explain why:**

- B. Which immunizations listed below have you received?

- |                                     |                                      |  |
|-------------------------------------|--------------------------------------|--|
| <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Rubella     | <input type="checkbox"/> Prevnar       |
| <input type="checkbox"/> Tetanus    | <input type="checkbox"/> Polio       | <input type="checkbox"/> Pneumovax     |
| <input type="checkbox"/> Measles    | <input type="checkbox"/> HIB         | <input type="checkbox"/> Meningococcal |
| <input type="checkbox"/> Mumps      | <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Varicella     |

- C. Please list any adverse reactions to any immunizations:
- D. Did you receive the influenza (flu) shot during the most recent or current flu season?  
Yes  No
- E. Do you plan to obtain the flu shot for the upcoming season? Yes  No

**13. FAMILY HISTORY: (please complete)**

Mother's health: age:  
Father's health: age:  
Brother(s)' health: age:  
Sister(s)' health: age:



Do any family members have a history of the following? *(If yes, please check all that apply)*

<b>Illness</b>	<b>Yes</b>	<b>No</b>	<b>List Relatives (indicate if outgrown and when)</b>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	
Cystic fibrosis or Other Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Hay fever/ Allergic rhinitis	<input type="checkbox"/>	<input type="checkbox"/>	
Chronic Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	
Hives/ Urticaria	<input type="checkbox"/>	<input type="checkbox"/>	
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	
Migraines	<input type="checkbox"/>	<input type="checkbox"/>	
Insect Allergy	<input type="checkbox"/>	<input type="checkbox"/>	
Drug Allergy	<input type="checkbox"/>	<input type="checkbox"/>	
Food Allergy	<input type="checkbox"/>	<input type="checkbox"/>	
Celiac Disease	<input type="checkbox"/>	<input type="checkbox"/>	
Immune disorders	<input type="checkbox"/>	<input type="checkbox"/>	
Autoimmune disorders (Lupus, thyroid disease, Rheumatoid arthritis)	<input type="checkbox"/>	<input type="checkbox"/>	
Inflammatory bowel disease	<input type="checkbox"/>	<input type="checkbox"/>	
Early unexplained death in infancy	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent miscarriages	<input type="checkbox"/>	<input type="checkbox"/>	

**14. ENVIRONMENTAL SURVEY:**

- A. Approximately how old is your home? \_\_\_\_\_ How long have you lived there? \_\_\_\_\_
- B. Is your home a(n):  single family home  brownstone/townhouse  apartment
- C. Does your home have:
- Central AC  Window AC  Wall Unit AC  HVAC (heat & AC) wall unit
- Forced heat  Radiator heat  Gas heat  Electric heat
- Humidifier  Damp areas  HEPA filter
- D. Do your windows have:  curtains  drapes  shades  blinds
- E. Does your **bedroom** have:  wall-to-wall carpeting  hardwood flooring  area rugs
- F. Where is your bedroom located? (floor or level of house)



- G. On your bed, are there:  
 Stuffed toys       Dust mite proof covers       Feather pillows  
 Synthetic pillows       Mattresses       Weekly washing of bed linens
- H. Do you have any pets (cats, dogs, birds, gerbils, hamsters, etc)?
- I. If you have pets, do they enter your child's  bedroom and/or  bed.
- J. Are there any pet animals at school or work? Yes  No
- K. Have you seen any pests in your home? Yes  No   
*If yes*, which pests? cockroaches  mice  rats  Other: \_\_\_\_\_
- L. Are you a smoker? Yes  No
- M. Are there any other smokers in the home? Yes  No
- N. What is your occupation?
- O. Other environmental or occupational exposures? Yes  No  Where? \_\_\_\_\_
- P. Are your symptoms worse at school/work than at home?
- Q. Are there **any other locations(s)** where the symptoms are worse?
- R. How many days have you missed school/work because of asthma or allergies?

**15. COMMENTS: (Are there any other issues you would like to discuss at your visit?)**

Signature of Patient/Legal Guardian

Date

**For the Physician:** Reviewed & Confirmed:

Date of Visit:



**Race and Ethnicity Information**

We want to make sure that all our patients get the best care possible. We would like you to tell us your child's racial and ethnic background as well as your preferred language so that we can review the treatment that all patients receive and make sure that everyone gets the highest quality of care. You may decline to answer if you wish.

The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

**Primary Language**

- |   |   |  |                                   |
|---|---|--|-----------------------------------|
| <input type="checkbox"/> Albanian           | <input type="checkbox"/> American Sign Language | <input type="checkbox"/> Arabic              | <input type="checkbox"/> Armenian |
| <input type="checkbox"/> Bengali            | <input type="checkbox"/> Bosnian                | <input type="checkbox"/> Cantonese (Chinese) |                                   |
| <input type="checkbox"/> Creole             | <input type="checkbox"/> Croatian               | <input type="checkbox"/> ECH                 | <input type="checkbox"/> Danish   |
| <input type="checkbox"/> English            | <input type="checkbox"/> French                 | <input type="checkbox"/> German              | <input type="checkbox"/> Greek    |
| <input type="checkbox"/> Hebrew             | <input type="checkbox"/> Hindi                  | <input type="checkbox"/> Indonesian          | <input type="checkbox"/> Italian  |
| <input type="checkbox"/> Japanese           | <input type="checkbox"/> Korean                 | <input type="checkbox"/> Latin               | <input type="checkbox"/> Malay    |
| <input type="checkbox"/> Mandarin (Chinese) |   | <input type="checkbox"/> Persian             | <input type="checkbox"/> Polish   |
| <input type="checkbox"/> Portuguese         | <input type="checkbox"/> Romanian               | <input type="checkbox"/> Russia              | <input type="checkbox"/> Serbian  |
| <input type="checkbox"/> Slovak             | <input type="checkbox"/> Spanish                | <input type="checkbox"/> Swahili             | <input type="checkbox"/> Swedish  |
| <input type="checkbox"/> Tagalog            | <input type="checkbox"/> Thai                   | <input type="checkbox"/> Turkish             | <input type="checkbox"/> Urdu     |
| <input type="checkbox"/> Vietnamese         | <input type="checkbox"/> Yiddish                | <input type="checkbox"/> Yugoslavian         | <input type="checkbox"/> Other    |
| <input type="checkbox"/> Declined           | <input type="checkbox"/> Unknown                |  |                                   |

**Race**

- |   |  |
|---|--|
| <input type="checkbox"/> American Indian or Alaska Native | <input type="checkbox"/> Asian                                   |
| <input type="checkbox"/> Black or African American        | <input type="checkbox"/> Native Hawaiian or Other Pacific Island |
| <input type="checkbox"/> White                            | <input type="checkbox"/> Other Combination Not Described         |
| <input type="checkbox"/> Declined                         |  |

**Ethnicity**

- Hispanic or Latino or Spanish Origin
- Not Hispanic or Latino or Spanish Origin
- Declined

**Pharmacy Information**

So that you and your physician may take advantage of e-prescribing, we need you to provide information on the pharmacy that you choose to use to fill you or your child's prescriptions. Electronic prescription requests are more efficient, accurate and cost effective. Feel free to speak with your physician if you have additional questions.

New

Date:

Patient Name:

NYH #:

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**PRIMARY**

Pharmacy Name:

Address:

Phone Number:

Fax Number:

**SECONDARY** (if applicable)

Pharmacy Name:

Address:

Phone Number:

Fax Number: