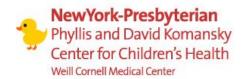


ADULT ALLERGY QUESTIONNAIRE

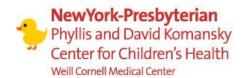
Today's	Date:		
Patient	's Name:	Date of Birth:	Age:
Addres	s:		Phone:
Referre	d To This Office By:		
Primary	/ Care Physician:		Phone:
Addres	S:		Fax:
1.	CHIEF COMPLAINT (reason for v	risit):	
2.	PRIOR ALLERGY EVALUATION AN	ND TREATMENT:	
	Have you been previously evalua	ited for allergies? Yes No	
	(If yes, complete this section)		
	Have you ever had an allergy skir	n test? Yes 🗌 No 🗌	
	If yes, Date: Res	sults:	
	Have you ever had an allergy blo	od test? Yes 🗌 No 🗌	
	If yes, Date: Res	sults:	
	Have you ever received immunot	therapy (allergy shots)? Yes 🔲 No 🗌	
	If yes, Dates: Fo	or what allergies?	





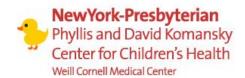
3.	FOOD REACT	TIONS: Yes No (If ye	es, complete this section)	
	Are you o	n any special diets? Avo	oiding any foods?	
	If ye	s, please list in the table below:		
	Food	Age Avoided	Symptoms	Still Avoiding?
	<u>roou</u>	Age Avoided	<u>Symptoms</u>	Still Avoluling:
	apples, pe	ave itching in your mouth after e eaches, pears, kiwi, citrus, toma s, please list specific food trigge	to, potato), shellfish, peanu	
4.	ASTHMA HIS	STORY: Yes No (If ye	s, complete this section)	
	Age of onset	: Frequency of attac	ks: Most recent e	xacerbation:
	Have you ev	er needed any of the following	for asthma? (Please answe	er with the most recent first.)
	Hospital adm	nissions:		
	Emergency r	oom visits:		
	ICU admissio	ns:		
	Intubations:			





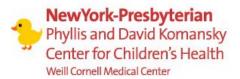
	Symptoms: Wheeze Cough Sputum Exercise Intolerance Chest Pain Shortness of breath					
	Night time cough: Yes No					
	Season worse in: Winter Spring Sun	nmer 🗌	Fall _			
	Triggers:					
5.	ALLERGY & ASTHMA TRIGGERS: (Please select	choices, c	heck "Y	es" or "No", and list sympto	ms)	
		<u>Yes</u>	<u>No</u>	<u>Symptoms</u>		
	Grass exposure					
	Tree exposure					
	Raking leaves Mowing lawn					
	Damp areas with mold and mildew					
	Sweeping Dusting Vacuuming					
	Smog Air Pollution					
	Temperature changes (hot cold)					
	Tobacco smoke					
	Exercise					
	Animals (cats, dogs, etc)					
	Coughing after drinking cold or hot water					
	Colds (Virals URI's)					
	Cleaning agents, fumes, perfumes					
	Others:					





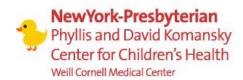
6.	. INSECT ALLERGY: Yes 🗌 No 🗌 (If yes, complete this section)							
	Insect: Unknown							
	Symptoms:							
	Local swelling	Generalized swelling	Hives					
	Pain	Wheezing	☐ Shortness of breath					
	☐ Throat tightening	☐ Difficulty swallowing	Loss of consciousness					
7.	LATEX ALLERGY: Yes \(\square\) No	(If yes, complete this section)						
	<u>Date</u> <u>Source</u>	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	ng medications:						
	Nasal Sprays: Rhi	inocort Flonase Nason	ex Nasacort Veramyst					
	☐ Ast	elin 🗌 Afrin 🔲 Other:						
	If yes, when, ar	nd at what dose & frequency?						
	Inhalers: Proventil, Advair		ovent Pulmicort Qvar hylline Other:					
	If yes, when, and at what dose & frequency? Last time used:							





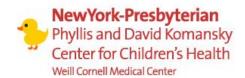
9.	MEDICATION/DRUG REACTIONS: Yes No (If yes, complete this section)					
	<u>Date</u> <u>Drug</u>		Reaction	<u>Taken Since</u>		
10.	. HISTORY OF REPEATED INFECT	TIONS: Yes	No (If yes, com	plete this section)		
	<u>Туре</u>	<u>Date</u>	Antibiotic needed	Abnormal tests (i.e. Chest X-rays/		
				CT Scans/Blood tests)		
	Ear Infections					
	Sinusitis					
	Pneumonia					
	Bronchitis					
	Meningitis					
	Dental Infections					
	Bladder/Kidney Infections					
	Skin Infections					
	Joint Infections					
	Gastrointestinal Infections					





11. (11. OTHER WIEDICAL/SURGICAL HISTORY: (Please answer all items)						
A	١.	List other medical illnesses:					
Е	3.	Any surgeries:					
C	<u>.</u>	Any ER visits/hospitalizations? For re	spiratory or allergic reactions? \	When?			
		What treatment did you receive	?				
[).	For women, are your menstrual perio	ods regular? Yes 🗌 No 🗌				
		Number of days in typical cycle:					
12. I	ΜN	MUNIZATIONS:					
Α	۸.	Are your immunizations up to date?	Yes No If no, explain	why:			
Е	3.	Which immunizations listed below ha	ave you received?				
		☐ Diphtheria ☐ Tetanus ☐ Measles ☐ Mumps	Rubella Polio HIB Hepatitis B	Prevnar Pneumovax Meningococcal Varicella			
C	.	Please list any adverse reactions to a	ny immunizations:				
C	D. Did you receive the influenza (flu) shot during the most recent or current flu season? Yes No						
Е		Do you plan to obtain the flu shot for	r the upcoming season? Yes] No 🗌			



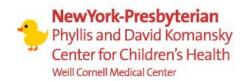


Mother's health:	age:	Father's health:	age:
Brother(s)' health:	age:	Sister(s)' health:	age:

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

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

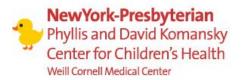




14. ENVIRONMENTAL SURVEY:

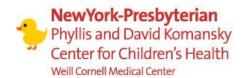
	LIST	City State Years Effects on Symptoms (better, worse, no change)
	1. 2. 3. 4.	
,	۹.	Approximately how old is your home? How long have you lived there?
I	В.	Is your home a(n): single family home brownstone/townhouse apartment
(C.	Does your home have: Central AC Window AC Wall Unit AC HVAC (heat & AC) wall unit Forced heat Gas heat Electric heat Humidifier Damp areas HEPA filter
١	D.	Do your windows have:
١	Ε.	Does your bedroom have: wall-to-wall carpeting hardwood flooring area rugs
١	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
ı	Н.	Do you have any pets (cats, dogs, birds, gerbils, hamsters, etc)?
ı	١.	If you have pets, do they enter your child's bedroom and/or bed.
	l.	Are there any pet animals at school or work? Yes No
ı	Κ.	Have you seen any pests in your home? Yes No Other:
ı	L.	Are you a smoker? Yes No
I	M.	Are there any other smokers in the home? Yes No
١	N.	What is your occupation?
(٥.	Other environmental or occupational exposures? Yes No Where?
I	Ρ.	Are your symptoms worse at school/work than at home?
(Q.	Are there any other locations(s) where the symptoms are worse?
١	R.	How many days have you missed school/work because of asthma or allergies?





15. COMMENTS	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 & Con	firmed:	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.

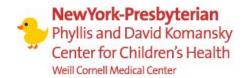
The only people who see this information are registration staff, administrators for the practice, your care providers, and the people involved in quality improvement and oversight, and the confidentiality of what you say is protected by law.

Please mark the appropriate response:

<u>Pri</u>	mary Language				
	Albanian	American Sign Language	Arabic	Armenian	
	Bengali	Bosnian	Cantonese (Chinese	<u> </u>	
	Creole	Croatian	☐ ECH	Danish	
	English	French	German	Greek	
	Hebrew	Hindi	Indonesian	Italian	
	Japanese		Latin	Malay	
	Mandarin (Chinese)		Persian	Polish	
	Portuguese	Romanian	Russia	Serbian	
	Slovak	Spanish	Swahili	Swedish	
	Tagalog	Thai	Turkish	Urdu	
	Vietnamese	☐ Yiddish	Yugoslavian	Other	
	Declined	Unknown			
Race American Indian or Alaska Native Black or African American White Other Combination Not Described Declined					
Eth	nnicity Hispanic or Latino or Not Hispanic or Latir Declined	•			



Fax Number:



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 #: **PRIMARY** Pharmacy Name: Address: Phone Number: Fax Number: **SECONDARY** (if applicable) Pharmacy Name: Address: Phone Number: