OAK BROOK allergists

NEW PATIENT QUESTIONNAIRE

Patient Name: _____ Date of Birth: _____

Today's Date: _____ What is the reason for your visit? _____

Referring MD: _____ Primary MD: _____

SYMPTOMS (Reason for your visit?)

□ Itchy □ Watery □ Burning Eyes
□ Ear Fullness/Pain
□ Runny / Itchy Nose
□ Sneezing
□ Nasal Congestion
□ Facial Pain and Pressure
□ Headaches
□ Loss of Sense of Smell
□ Post Nasal Drainage
□ Hoarseness
□ Throat Clearing
□ Coughing
□ Shortness of Breath
□ Wheezing
□ Chest Tightness
□ Rash / Itching
□ Swelling of Lips □ Tongue
□ Swelling of Hands □ Feet

ALLERGY HISTORY

Do you have allergies or hay fever? □ Yes □ No Are symptoms □ SEASONAL and/or □ YEAR ROUND?
Medications tried: _____
Have you been tested for allergies? □ Yes □ No How? □ Skin testing and/or □ Blood Test
Have you ever received allergy injections? □ Yes □ No For how long?_____ When?_____
Did they help? □ Yes □ No
Do you have a history of allergies to the following? □ Foods □ Latex □ Insect Stings □ Antibiotics
□ Other_____

SINUS HISTORY

Do have a history of sinus problems? □ Yes □ No History of Nasal Polyps? □ Yes □ No
Color of drainage today? _____
How many times have you been treated for sinus infection in the last year? _____
Have you ever had an Xray or CT scan of your sinuses? □ Yes □ No
When/Results? _____
Have you ever had sinus surgery? □ Yes □ No If yes, When? _____ Was it helpful? _____
Have you ever received a pneumonia vaccine? □ Yes □ No
Do you usually get a flu shot each year? □ Yes □ No

ASTHMA HISTORY

Have you ever been diagnosed with asthma? □ Yes □ No If yes, When? _____
Have you ever been to the Emergency Room because of your asthma? □ Yes □ No How often? _____
Have you ever been hospitalized overnight for breathing difficulty? □ Yes □ No How often? _____
Have you ever missed school or work due to your asthma? □ Yes □ No How often in the last year? _____
How many times in the last year have you had to take oral or injected steroids? _____
Medications tried: _____

Rev. 5/26/20

Patient Name: _____

FOOD ALLERGY HISTORY

Have you ever had a reaction to a food? □ Yes □ No If yes, what food and when? _____
Currently avoided foods: _____
Last reaction: Food _____ Year _____
Symptoms □ Hives □ Swelling (location _____) □ Vomiting □ Cough/Wheeze
□ Other_____
Last food allergy testing: □ Skin testing (year: _____) □ Bloodwork (year: _____)
Do you have an epinephrine autoinjector? □ Yes □ No
Have you participated in any form of food allergy treatment or oral immunotherapy? □ Yes □ No

REVIEW OF SYSTEMS **(Do you have any of the following?)**

□ Fever
□ Chills/Night Sweats
□ Weight Change
□ Fatigue
□ Difficulty Sleeping
□ Snoring
□ Lightheadedness
□ Heart Palpitations
□ Chest Pain
□ Heartburn / Indigestion
□ Nausea / Vomiting
□ Constipation / Bloating
□ Diarrhea
□ Urinary Abnormalities
□ Dizziness / Vertigo
□ Muscle Weakness
□ Muscle Aches/Pain
□ Joint Pain / Swelling
□ Back Pain / Stiffness
□ Swollen Legs / Ankles
□ Easy Bleeding / Bruising
□ Skin Rash / Hives / Eczema
□ Depression / Feeling Blue
□ Anxiety / Stress

PAST MEDICAL HISTORY

□ Eczema
□ Bronchitis
□ Pneumonia
□ COPD
□ Obstructive Sleep Apnea
□ Migraine Headaches
□ Glaucoma
□ Recurrent Ear Infections
□ Bowel / Intestinal Disorder
□ Acid Reflux
□ Kidney Disease
□ Liver Disease
□ High Blood Pressure
□ High Cholesterol
□ Heart Disease
□ Diabetes
□ Thyroid Disease
□ Arthritis
□ Autoimmune Disease (Type _____)
□ Cancer (Type _____)
□ Anxiety
□ Depression
□ ADHD

Surgeries/Hospitalizations (include year) _____

FAMILY HISTORY

Allergies / Hay Fever	□ Mother	□ Father	□ Sibling	□ Child	□ Aunt/Uncle	□ Grandparent
Asthma	□ Mother	□ Father	□ Sibling	□ Child	□ Aunt/Uncle	□ Grandparent
Sinus Disease	□ Mother	□ Father	□ Sibling	□ Child	□ Aunt/Uncle	□ Grandparent
COPD	□ Mother	□ Father	□ Sibling	□ Child	□ Aunt/Uncle	□ Grandparent
Cystic Fibrosis	□ Mother	□ Father	□ Sibling	□ Child	□ Aunt/Uncle	□ Grandparent
Autoimmune Disease	□ Mother	□ Father	□ Sibling	□ Child	□ Aunt/Uncle	□ Grandparent
Immunodeficiency	□ Mother	□ Father	□ Sibling	□ Child	□ Aunt/Uncle	□ Grandparent

Other: _____

Patient Name: _____

SOCIAL HISTORY

Occupation: _____ Any Concerning Work Exposures: _____
Hobbies: _____
Do you use/have you used tobacco products? □ Yes □ No □ Past What type? □ Cigarettes □ Cigars □ Pipes □ Chew
How many per day? _____ For how many years? _____ If you stopped/quit, when? _____
Have you been exposed to second hand smoke? □ Yes □ No Where? _____
Do you use alcohol? □ Yes □ No # of drinks per week? _____ Other drug use? □ Yes □ No
Any recent travel outside of U.S.? □ Yes □ No

ENVIRONMENTAL HISTORY

Do you have pets at home? □ Cats □ Dogs □ Other _____ □ Inside □ Outside □ Both
Do your pets sleep in your bedroom? □ Yes □ No Do pets make your symptoms worse? □ Yes □ No
Has there been any water leakage/damage in your home? □ Yes □ No
If yes, has it been professionally remedied? □ Yes □ No
What type of Flooring is in your home? □ Carpet □ Hardwood □ Laminate □Tile □ Vinyl
Bedroom has _____ ?
Age of Home? _____ Years lived there? _____ What type of heating unit do you have? _____
A/C? □ Yes □ No What type? _____
How frequently do you change filters in your home? _____
Which of the following do you use in your home:
□HEPA Filter □ Humidifier □ Dehumidifier □ Dust Mite Covers for Mattress

MEDICATION ALLERGIES **(Please list any avoided medications and reason below)**

_____

_____

_____

CURRENT MEDICATIONS **(Please list all medications/supplements below or attach list)**

Medication	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____