ATLANTIC ALLERGY & ASTHMA CENTER, P.C.
PATIENT QUESTIONNAIRE rev 9/25/17

Name: _____ Age: _____ Today's Date: _____

Reason for Office Visit: _____
_____

Please list current prescription and non-prescription medications:

_____ _____

_____ _____

_____ _____

_____ _____

Last dose of antihistamines(Benadryl, Claritin, loratadine, zyrtec, cetirizine, azelastine etc: _____

What is your approximate: height_____ weight_____

PAST MEDICAL HISTORY

	Yes	No		Yes	No		Yes	No
Asthma			Heart Attack			Mitral Valve Prolapse		
Arthritis			Heart Disease			Prostate Condition		
Bladder Condition			Hypertension			Psoriasis		
Eczema			Hyperthyroidism			Stroke		
Emphysema			Hypothyroidism			Seizure Disorder		
Diabetes			Hepatitis			Vertigo		
Gastroesophagel reflux-GERD			Meningitis					
Glaucoma			Meniere's Disease					

Any other conditions not listed above: _____
_____
_____

RECENT SINUS/EAR/COUGH HISTORY

Have you had any of the following in the past **12 months**? How many?
Ear Infections_____ Sinus Infections_____ Bronchitis_____ Pneumonia_____

HOSPITALIZATION HISTORY

Have you been **HOSPITALIZED/EMERGENCY ROOM** in past 12 months? _____ When and why? _____
_____
_____

PAST SURGICAL HISTORY

Have you had any surgical procedures? (*Circle one*) Yes no If yes, please list type of surgery and dates _____
_____

IMMUNIZATION HISTORY

Have you ever received the *pneumonia vaccine?* (*Circle one*) Yes no don't know when?_____

Did you get the *Influenza vaccine* sometime between August 1, 2017 – December 31, 2017? (circle one) yes no not applicable

PAST ALLERGY EVALUATION

Have you had allergy testing? (*Circle one*) Yes No When? _____

What were you **skin test** allergic to? (*Circle any*) ragweed grass dust mold trees cat dog **unsure**

Did you receive allergy shots? (*Circle one*) yes no how long? _____ why did you stop? _____
_____

FAMILY HISTORY

Do you have family members with allergies, asthma, eczema or hives? (*Circle one*) yes no

Which family member?_____ What type of allergy problem?_____

Which family member?_____ What type of allergy problem?_____

Which family member?_____ What type of allergy problem?_____

ENVIRONMENTAL HISTORY

Do you live in a (circle one) house apartment other_____ How long have you lived there? _____

How **old** *(based on original built date)* is you house/apartment complex/dwelling? _____ Years How many floors? _____

What type of heat? *(Circle)* forced air radiator baseboard fireplace woodstove

Do you have air-conditioning? *(Circle)* window units central none

Do you have (circle one) none slab basement crawlspace

Is the basement/crawlspace damp dry (*Circle*) Is the basement? finished unfinished (Circle)

Does your home have moisture problems? Yes no Is there any visible mold? yes no If so, where_____

What type of flooring do you have in your family room? Wall-to-wall carpet hardwood area rug tile

Do you have any houseplants? Yes no How many? _____ Do you have a HEPA vacuum cleaner? Yes no I don't know

BEDROOM

What type of mattress do you have *(Circle*) Standard memory foam pillow top other_____

Do you have allergy-proof covers on your mattress? *(Circle)* yes no Pillows? *(Circle*) yes no

What type of pillows?(circle) None Poly down foam other_____

Do you have an air cleaner in your bedroom? (circle) yes no

What type of flooring do you have in your bedroom? Wall-to-wall carpet hardwood area rug tile

PETS

Do you have any pets at home? *(Circle any)* ***n*one** dog (how long in home) _____ cat (how long in home) _____

rabbit((how long in home) _____ hamsters(how long in home)_____ Guinea Pig (how long in home) _____

birds_____ horses _____ others_____

If living in home less than 6 months, were there any pets in this home previously? (*Circle) n*ot applicable no if yes what? _____

Do you have any exposure to pets at friends or relatives? (*Circle one)* Yes No How often? _____

What type of animal? Dog cat bird other_____

SOCIAL HISTORY

Do you presently smoke? (*Circle one)* Yes No if so, how many packs per day? _____ For how many years *have you* smoked? _____

If you quit, for how many years *did you* smoke? _____years When you smoked approx. how many packs/day did you smoke _____

What year did you quit?_____

Have you smoked at least 100 cigarettes in your entire life? (Circle one) yes no

Does anyone else smoke in the home?(circle one) yes no if yes, who? _____

Did you ever use smokeless tobacco*(Circle one)* yes no

Do you use recreational drugs? (*Circle one)* Yes No

Do you consume alcohol? (*Circle one)* Yes No social other_____

EXPOSURE

If patient is a child, are they in *(circle one)* daycare, preschool, school, homeschooled or other _____How often? _____

Any siblings? _____ Ages of sibling_____

WORK ENVIRONMENT

Does the **patient** work? Yes no Occupation: _____

Any workplace exposures to the following? *(circle any)* smoke molds pet dander Other_____

PAST DRUG ALLERGY HISTORY

Does the PATIENT have any allergies to medications(Do not list sensitivities)? (circle one) Yes no

Please list any ***DRUG ALLERGIES***_____