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

☐ 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

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 ☐ Skin 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

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

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 _____

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OAK BROOK allergists

PATIENT NAME _____

REVIEW OF SYSTEMS

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

PAST MEDICAL HISTORY

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

Surgeries / Hospitalization (include year) _____

PEDIATRIC HISTORY (Patients under 18)

Birth History ☐ Preterm ☐ Full Term (>37 weeks) -- ☐ C-Section ☐ Vaginal Birth

Vaccine History ☐ Fully Vaccinated ☐ Delayed ☐ Unvaccinated

Has your pediatrician expressed concerns for patient regarding growth and/or development? ☐ Yes ☐ No

If yes, please list therapies (Examples: Physical or Occupational Therapy) _____

Please mark all that your child has attended: Daycare ___ Home Child Care ___ Preschool ____ School ___ (Grade ____)

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 _____

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OAK BROOK allergists

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 ? _____

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