Phoenix Allergy & Asthma
Adult and Pediatric Allergy and Asthma Care

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NEW PATIENT QUESTIONNAIRE

Name: _____ **DOB:** _____ **Date:** _____

The Reason for Your Visit?

_____

_____

When did this problem start? _____

Prior Diagnostic History: Have you ever had any of the following:

- ☐ Chest X-Ray
- ☐ CT Scan of Sinuses
- ☐ CT of Chest
- ☐ Allergy Skin Testing
- ☐ Allergy Shots

Smoking History:

- ☐ Non-Smoker
- ☐ Former Smoker: Start _____ Stop _____
- ☐ Current Smoker:_____ packs per day, for ____ years
- ☐ Exposed to second-hand smoke

Pets:

- ☐ Dog(s) # _____
- ☐ Cat(s) # _____
- ☐ Bird(s) #_____
- ☐ Other _____

Home:

Carpet? Yes No Where?_____

- ☐ Tile
- ☐ Wood Floors

Occupation: _____

What are the symptoms you are having:

- ☐ Itchy Nose
- ☐ Runny Nose
- ☐ Post-Nasal Drip
- ☐ Shortness of Breath
- ☐ Congestion
- ☐ Itchy Throat
- ☐ Itchy Eyes
- ☐ Watery Eyes
- ☐ Sinus Infection
- ☐ Swollen Eyes
- ☐ Hives
- ☐ Itchy Rash
- ☐ Cough
- ☐ Sneezing
- ☐ Wheezing
- ☐ Difficulty Swallowing
- ☐ Lip Swelling
- ☐ Non-Itchy Rash

Other _____

How Long Have You Had These Symptoms? _____

How Often Do You Experience These Symptoms?_____

When Are They Worse? (circle) Spring Fall Summer Winter Other_____

What Do You Think Causes These Symptoms?

- ☐ Grasses
- ☐ Weeds
- ☐ Trees
- ☐ Windy Weather
- ☐ Molds
- ☐ Indoors
- ☐ Outdoors
- ☐ Furry Pets
- ☐ Perfumes
- ☐ Air Conditioning
- ☐ Changes in Weather
- ☐ Tabacco Smoke

Other _____

All Medication (including Inhalers) You are Currently Taking:

Medication Name	Dose	Frequency

Past Medical History:

- ☐ Diabetes
- ☐ Cataracts
- ☐ Osteoporosis/Osteopenia
- ☐ Glaucoma
- ☐ Thyroid Disease (high or low)
- ☐ Autoimmune Disease
- ☐ COPD, Chronic Bronchitis, Emphysema
- ☐ High Blood Pressure
- ☐ GERD, Acid Reflux
- ☐ Stroke
- ☐ Pneumonia
- ☐ Asthma
- ☐ Allergic Rhinitis/Hay Fever
- ☐ Bronchitis
- ☐ Heart Attack
- ☐ Valley Fever
- ☐ Sleep Apnea
- ☐ Cancer Type:_____ How was it Treated? ___ Chemotherapy ___ Radiation ___ Surgery
- ☐ Other _____

Recent Surgeries and Dates:_____
Any Medication Allergies? ___ NO ___ YES (Describe Reaction) _____

Family History	Seasonal Allergies	Asthma	Eczema	Food Allergies	Other
Father					
Mother					
Brother					
Sister					
Daughter					
Son					

REVIEW OF SYSTEMS: Please check if you have any of the following:

GENERAL: ☐ None ☐ unexplained weight gain or loss ☐ unexplained fevers or shaking chills ☐ night sweats

SKIN/BREASTS: ☐ None ☐ Breast lumps ☐ Nipple discharge ☐ Hives ☐ Eczema
☐ Other rashes: _____

EYES/EARS/NOSE/MOUTH/THROAT: ☐ None ☐ Headaches ☐ Congestion ☐ Visual changes
☐ Nosebleeds ☐ Runny Nose ☐ hoarseness ☐ tightness in the throat or choking sensation

CARDIOVASCULAR: ☐ None ☐ palpitations/racing or fluttering of heart ☐ heart murmur ☐ irregular heart rhythm
☐ swelling of the feet/ankles ☐ shortness of breath when lying flat

RESPIRATORY: ☐ None ☐ shortness of breath ☐ wheezing
☐ Cough If yes, do you bring up mucous? ☐ No ☐ Yes If yes, what does it look like? ☐ clear ☐ whitish ☐ dark yellow/green/brown Other: _____ Do you cough up blood? ☐ Yes ☐ No

GASTROINTESTINAL: ☐ None ☐ Nausea ☐ Vomiting ☐ abdominal cramping ☐ diarrhea ☐ blood in stool ☐ heartburn
☐ taste of vomit in the mouth without vomiting ☐ food sticking when swallowing ☐ impaired liver function

GENITOURINARY: □ None □ blood in urine □ trouble urinating □ history of kidney stones
□ waking up more than 3 times at night to urinate □ impaired kidney function

MUSCULOSKELETAL: □ None □ red, hot swollen joints □ pain in joints □ arthritis

NEUROLOGIC/PSYCHIATRIC: □ None □ seizures □ anxiety □ depression □ thoughts of suicide

LYMPHATIC: Have you noticed any enlarged or swollen lymph nodes that won't go away? □ No □ Yes
If yes, where? □ neck □ over the collar bones □ armpits □ borders between thigh and pelvis

ADDITIONAL HISTORY THAT YOU WANTED US TO KNOW: _____