INTAKE QUESTIONNAIRE

ALLERGY, ASTHMA & RESPIRATORY CARE MEDICAL CENTER

PLEASE PRINT CLEARLY

Name (Last) (First)	□ Male □ Female Race: Date of Birth: Age:	Date:
	____ ____/____/____ ____	

Street Address	City	State	Zip

Home Phone #	Work Phone #	Cell Phone #
E-Mail Address	**Who is your Primary Care Physician?**	**Referral Source:**
Occupation:	**Hobbies:**	
If married, spouse's occupation:	**Spouse's hobbies:**	

IF PATIENT IS A CHILD, COMPLETE THE FOLLOWING

Father's Complete Name:	Age:	Occupation:	Hobbies:
Mother's Complete Name:	**Age:**	**Occupation:**	**Hobbies:**

ALCOHOL CONSUMPTION	CURRENT SMOKING HABITS
□None □ Social □ Regular Drinks per week_____	□Current □Never □ Quit. If quit, what year? _____ If current or quit, _____# packs/day, # of years smoked _____

IF FEMALE:	IF CHILDBEARING POTENTIAL:
□ Last Menstrual Period ____-____-_____	□ Oral Contraceptive (how long) _____
□ Post-Menopausal (without periods) _____	□ IUD (how long) _____
□ Hysterectomy (year)_____	□ Double Barrier
□ Tubal Ligation (year) _____	□ Partner Vasectomy _____

PRESENT MEDICATIONS

Medication	Dose & Frequency	Reason	Date Started	Date Stopped

PAST MEDICAL HISTORY

EARS, EYES, NOSE, AND THROAT			Date Symptoms started or Diagnosed	CHECK IF CURRENT
Allergies	Y	N		☐
☐ Seasonal ☐ Yr Round				
Impaired Hearing	Y	N		☐
Chronic Sinusitis	Y	N		☐
Glasses/Contacts	Y	N		☐
☐ Farsighted ☐ Nearsighted				
Glaucoma	Y	N		☐
Cataracts	Y	N		☐
RESPIRATORY				
Asthma	Y	N		☐
Bronchitis	Y	N		☐
Pneumonia	Y	N		☐
COPD	Y	N		☐
GENITOURINARY				
Enlarged Prostate	Y	N		☐
Frequent bladder infections	Y	N		☐
Kidney disease	Y	N		☐
HEMATOLOGICAL				
Blood disorders	Y	N		☐
Anemia	Y	N		☐
DERMATOLOGICAL				
Eczema/Atopic Dermatitis	Y	N		☐
Psoriasis	Y	N		☐
Acne	Y	N		☐
MUSCOLOSKELETAL				
Carpal Tunnel Syndrome	Y	N		☐
Arthritis	Y	N		☐
Broken Bones (specify)	Y	N		☐
GYNECOLOGICAL				
Ovarian Cysts/Tumors	Y	N		☐
Uterine Cysts/Tumors	Y	N		☐
ENDOCRINE				
Diabetes	Y	N		☐
Thyroid	Y	N		☐

CARDIOVASCULAR			Date Symptoms started or Diagnosed	CHECK IF CURRENT
Chest pain/ Angina	Y	N		☐
Heart Attack	Y	N		☐
Hypertension	Y	N		☐
Heart Murmur	Y	N		☐
Mitral Valve Prolapse	Y	N		☐
Phlebitis	Y	N		☐
High Cholesterol	Y	N		☐
GASTROINTESTINAL				
Gastric ulcer	Y	N		☐
Duodenal ulcer	Y	N		☐
Gall bladder disease	Y	N		☐
Constipation	Y	N		☐
Hemorrhoids	Y	N		☐
Diarrhea	Y	N		☐
Heartburn/Indigestion	Y	N		☐
Esophageal Stricture	Y	N		☐
NEUROPSYCHIATRIC				
Depression	Y	N		☐
Convulsions/Seizures	Y	N		☐
Stroke	Y	N		☐
Paralysis	Y	N		☐
Migraines/Headaches	Y	N		☐
ALLERGIES				
Drug Allergies	Y	N		☐
Food Allergies	Y	N		☐
IMMUNOLOGICAL				
HIV	Y	N		☐
Hepatitis (specify)	Y	N		☐
OTHER				
1)				☐
2)				☐
3)				☐
4)				☐
5)				☐

SURGERIES AND PROCEDURES or ☐ None

Procedures	Date	Procedures	Date

HOSPITALIZATION or ☐ None

Date	Reason	Location

ASTHMA/COPD HISTORY (circle one) or □ None

When were you first diagnosed with asthma/COPD? _____

How many hospitalizations due to asthma/COPD? _____ Most Recent: _____ How long? _____

Last use of IM/PO steroids in the last two years: _____ How many steroids burst in the last year? _____

How many ER visits? _____ Most recent:: _____ # of school/work days missed in past year? _____

When did your asthma/COPD symptoms begin? _____

In your own words, describe the most distressing symptoms you feel which are caused by your asthma/COPD:

ALLERGY RHINITIS HISTORY or □ NONE

1) When did you first have symptoms of nasal allergies? _____

2) Do you have □ runny nose □ sinus head aches □ post nasal drainage □ fatigue from allergies
□ nasal congestion □ sinus pressure □ loss of smell □ lack of concentration from allergies

3) Are your allergies active during: □ Spring □ Summer □ Fall □ Winter □ Year round

4) Triggers of your allergies? (check all that apply)

□ at night	□ Dogs	□ house dust	□ Santa Ana winds	□ at play
□ at work	□ Cats	□ certain foods	□ with air conditioning	
□ upon awakening	□ feathers	□ mowed grass	□ with menstrual period	

5) HAVE YOU EVER HAD SINUS X-RAYS? □ NO □ YES INDICATE APPROXIMATE DATE _____
WHAT WERE THE RESULTS? _____

SKIN ALLERGY

□ None □ Eczema □ Hives

Describe factors which make your rash worse :

_____

_____

CHILDHOOD HISTORY

□ Croup □ Infantile □ Frequent Ear Infection

□ Frequent Bronchial Infection

□ Other : _____

_____

FOOD ALLERGY

□ No

□ Yes, please indicate food type and allergic reaction:

_____

LATEX ALLERGY □ No □ Yes

Any reaction to gloves or condom exposure? □ No □ Yes

If yes, please decribe in detail : _____

_____

DRUG ALLERGIES or □ None

□ Aspirin □ Sulfa □ Local anesthetic

□ Penicilin □ X-ray dyes □ Other: _____

Describe reaction: _____

_____

REACTIONS TO INSECTS or □ None

□ Bee □ Wasp □ Yellow Jacket

□ Hornet □ Ant □ Other: _____

Describe reaction: _____

_____

FAMILY HISTORY	HAYFEVER OR NASAL SYMPTOMS	SINUS	ASTHMA	CHRONIC LUNG DISEASE OR EMPHYSEMA	FOOD ALLERGY	HIVES OR SWELLING	ECZEMA
MOTHER	☐	☐	☐	☐	☐	☐	☐
FATHER	☐	☐	☐	☐	☐	☐	
BROTHERS/SISTERS	☐	☐	☐	☐	☐	☐	☐
CHILDREN	☐	☐	☐	☐	☐	☐	☐

ARE THERE GRANDPARENTS, AUNTS OR UNCLES WITH ALLERGY PROBLEMS? ☐ NO ☐ YES, please explain _____

CHECK OR COMPLETE THE ANSWERS THAT BEST DESCRIBE YOUR HOME ENVIRONMENT

TYPE OF HOME
☐ APARTMENT ☐ DORMITORY
☐ MOBILEHOME ☐ HOUSE ☐ CONDOMINIUM

LOCATION OF HOME
☐ SEASHORE ☐ MOUNTAIN ☐ CITY
☐ COUNTRYSIDE ☐ DESERT

IS THERE OBVIOUS?
☐ MILDEW OR WATER DAMAGE
☐ ROACHES

INDICATE INDOOR PETS YOU HAVE
☐ CAT ☐ DOG ☐ BIRD ☐ OTHER

BEDROOM HAS: ☐ HEATING ☐ HUMIDIFIER
☐ AIR PURIFIER ☐ AIR CONDITIONING

Type of bedroom floor covering:
☐ Carpet ☐ Linoleum or tile ☐ Wood ☐ Other:_____

Type of Pillows you have: Age of pillow in years:_____
☐ Feather ☐ Dacron/Synthetic ☐ Foam Rubber ☐ Zip cover

Is there a smoker in your residence? ☐ No ☐ Yes If yes, relationship:_____

INDICATE TYPE OF ALLERGY TESTS TAKEN BEFORE ☐NONE ☐ BLOOD ☐ SKIN ☐ OTHER:_____

INDICATE WHAT THE TESTS WERE POSITIVE TO: ☐ POLLENS ☐ MOLDS ☐ FOODS ☐ DUST ☐ ANIMALS ☐ OTHER

HAVE YOU EVER RECEIVED CORTISONE-LIKE DRUGS (PREDNISONE, DECADRON, STEROIDS)? ☐ NO ☐ YES IF YES, DATES _____ DOSE _____ HOW LONG _____

HAVE YOU RECEIVED ALLERGY SHOTS? ☐ NO ☐ YES IF YES, WHEN? DATES: FROM _____ TO _____

HOW HELPFUL WERE THE SHOTS? ☐ MINIMAL HELP ☐ REACTIONS ☐ HELPFUL ☐ NO HELP

NAME AND LOCATION OF DOCTOR WHO GAVE YOU SHOTS?