FERRELL-DUNCAN CLINIC -- ALLERGY/IMMUNOLOGY

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Name: ________________________ ____________________________ ___________________________________

First Middle Last

Age: _______ Height: _______ Weight: ______

Date of Birth: ___________________ Home Phone: ______________________

Address: ____ Cell Phone: ________________________

____ Work Phone: _______________________

Were you referred by a physician/health care provider? □ Yes □ No

If Yes, please provide us with the name, address, and phone number of the physician referring you:

____

____

____

Would you like us to send a letter to your primary care provider regarding your visit with us? □ Yes □ No

If Yes, please provide us with the name, address, and phone number of your primary care provider:

□ Same as referring provider

____

____

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If there are other providers whom you wish to receive copies of our evaluation, please list the names, addresses, and phone numbers here:

____

____

The following new patient questionnaire is detailed. Please take the time to fill it out before your visit to help you recall important features of your condition and help our providers diagnose and treat you. Thank you!

____ ______________________

Allergy Physician/NP Signature Date

Current Medications:

Medication name	Dose	Frequency	Last taken when?

Previous Allergy/Asthma Medications You Have Taken:

Medication name	Did it help?	Last taken when?
	□ No □ Yes	
	□ No □ Yes	
	□ No □ Yes	
	□ No □ Yes	

Medication/Food/Other Allergies:

Have you ever had an adverse/allergic reaction to a medication, food, chemical, or other product? □ No □ Yes

If yes, please describe to what drug(s)/food(s)/other product(s), approximate year of the reaction, and type of reaction.

Medication/food/product name	Year	Type of reaction

Past Medical History:

Major Diagnoses/Illnesses: ____

____

____

____

____

____

Surgical History: ____

____

____

____

Immunizations: Year of last Tetanus shot: _________ Year of last seasonal flu shot: _________

Year of last pneumonia shot: __________

Up to date on childhood immunizations: □ Yes □ No

Describe any reactions to immunizations: ____

REVIEW OF SYSTEMS

System			
General:	☐ Chills ☐ Decreased appetite ☐ Fatigue ☐ Fever	☐ Malaise (general feeling of illness) ☐ Sweating ☐ Weight gain ☐ Weight loss	
Eye:	☐ Blurred vision ☐ Double vision ☐ Drainage ☐ Itching ☐ Pain	☐ Photophobia (light sensitivity) ☐ Redness ☐ Tearing/watering ☐ Vision loss ☐ Visual changes	
ENT:	☐ Decreased hearing ☐ Dental pain ☐ Ear drainage ☐ Ear pain ☐ Frequent nosebleeds ☐ Hoarseness	☐ Loss of smell ☐ Nasal congestion ☐ Postnasal drip ☐ Rhinorrhea (runny nose) ☐ Sinus pressure ☐ Sore throat	☐ Swollen glands ☐ Tinnitus (ringing in the ears)
Cardiovascular:	☐ Chest pain ☐ Shortness of breath with exertion ☐ Edema (leg swelling)	☐ Fainting ☐ Palpitations (heart racing/skipping beats)	
Respiratory:	☐ Cough ☐ Shortness of breath at rest	☐ Snoring ☐ Wheezing	
GI:	☐ Constipation	☐ Diarrhea ☐ Heartburn	☐ Nausea ☐ Vomiting
GU:	☐ Blood in the urine ☐ Frequent urination	☐ Painful urination ☐ Night time urination	☐ Incontinence
MS:	☐ Joint pain ☐ Joint swelling	☐ Muscle pain	☐ Muscle weakness
Skin:	☐ Pruritis (itching)	☐ Rash	
Neuro:	☐ Memory problems	☐ Seizures	☐ Vertigo (dizziness)
Psych:	☐ Anxious mood	☐ Depressed mood	☐ Poor attention span
Endocrine:	☐ Change in hair texture	☐ Temperature intolerance	
Heme/Lymph:	☐ Abnormal bruising		
Allergy/Imm:	☐ Frequent infections	☐ Hives	☐ Seasonal allergies

FAMILY HISTORY

	Mother	Father	Sister	Brother	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father	Other Family Member (list relationship)
Angioedema (lip swelling)	□	□	□	□	□	□	□	□	____________
Asthma	□	□	□	□	□	□	□	□	____________
Autoimmune disease	□	□	□	□	□	□	□	□	____________
Cancer	□	□	□	□	□	□	□	□	____________
Cystic Fibrosis	□	□	□	□	□	□	□	□	____________
Diabetes	□	□	□	□	□	□	□	□	____________
Eczema	□	□	□	□	□	□	□	□	____________
Emphysema	□	□	□	□	□	□	□	□	____________
Food allergies	□	□	□	□	□	□	□	□	____________
Heart disease	□	□	□	□	□	□	□	□	____________
Hives	□	□	□	□	□	□	□	□	____________
Seasonal allergies	□	□	□	□	□	□	□	□	____________
Thyroid disease	□	□	□	□	□	□	□	□	____________

SOCIAL HISTORY

Tobacco Use:

- □ Current smoker – every day
- □ Current smoker – some days
- □ Former smoker
  - □ Quit less than 30 days ago
  - □ Quit more than 30 days ago
- □ Never smoked

Number of years used: _______

Stopped at age: _______

Type:

- □ Chewing tobacco
- □ Cigarettes
- □ Cigars
- □ Pipe
- □ E-cigs/Vaping/Juul
- □ Other ________________

Tobacco Use Per Day:

- □ <=4 cigarettes/day
- □ 5-9 cigarettes/day
- □ 10+ cigarettes/day
- □ 1 pack per day
- □ 1 1/2 packs per day
- □ 2 packs per day
- □ 3 packs per day
- □ Other ________________

Are there smokers in the patient's home? □ Yes □ No

Alcohol: □ None □ Past □ Current (indicate frequency): ______________________________________

Substance Use: □ None □ Past □ Current (indicate type & frequency): ________________________________

Home:

Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Lives with: □ Alone □ Children □ Father □ Mother
□ Siblings □ Significant Other □ Spouse □ Other ______________________

Hobbies: ____

Employment/School: □ Full time □ Part time □ Student □ Retired □ Unemployed
□ Disability □ Homemaker □ Other _____________________________________

Occupation: ____

Allergens: Days of work/school missed yearly on average due to respiratory symptoms: __________

Air Conditioning:
- ☐ Central
- ☐ Makes symptoms better
- ☐ Window unit
- ☐ None
- ☐ Other: _____________________

Air Filter:
- ☐ Disposable
- ☐ Electronic
- ☐ Electrostatic
- ☐ HEPA filter
- ☐ Other: ________________

Basement:
- ☐ Damp
- ☐ Dry
- ☐ Dehumidifier in use
- ☐ Finished
- ☐ Musty
- ☐ N/A (crawlspace)
- ☐ N/A (slab home)
- ☐ Other: _____________________

Bedding:
- ☐ Washed in cold water
- ☐ Washed in hot water
- ☐ Washed weekly
- ☐ Washed monthly
- ☐ Other: ______________________

Bedroom Curtains:
- ☐ Blinds
- ☐ Cloth curtains
- ☐ Shades
- ☐ Other: _________________

Bedroom Flooring:
- ☐ Area rug
- ☐ Carpet
- ☐ Hardwood
- ☐ Linoleum
- ☐ Tile
- ☐ Other: _____________________
- ☐ Other: _____________________

Bedroom Location: ☐ Above ground ☐ In basement

Cat:
- ☐ Indoor
- ☐ Outdoor
- ☐ At daycare
- ☐ None
- ☐ Cat(s) sleep in bed

Dog:
- ☐ Indoor
- ☐ Outdoor
- ☐ At daycare
- ☐ None
- ☐ Dog(s) sleep in bed

Home Heat Source:
- ☐ Electric
- ☐ Natural gas
- ☐ Propane
- ☐ Wood
- ☐ Other: _____________________

Home Type:
- ☐ Apartment
- ☐ City/suburban
- ☐ House
- ☐ Townhouse
- ☐ Rural/farm
- ☐ Other: _______________________

Housedust Precautions:
- ☐ Implemented
- ☐ Partially implemented
- ☐ Not implemented

Humidifier:
- ☐ Attached to furnace
- ☐Free standing
- ☐ None

Main Flooring:
- ☐ Area rug
- ☐ Carpet
- ☐ Hardwood
- ☐ Linoleum
- ☐ Tile
- ☐ Other: _______________________

Mattress:
- ☐ Dust proof/allergy cover
- ☐ New
- ☐ Old
- ☐ Standard
- ☐ Waterbed
- ☐ Other: _________________

Other Pets:
- ☐ Birds
- ☐ Guinea pigs/hamsters
- ☐ Horses
- ☐ Rabbits
- ☐ Other: _____________________

Pillow:
- ☐ Dust proof/allergy cover
- ☐ Feather
- ☐ New
- ☐ Old
- ☐ Synthetic
- ☐ Other: _______________________

Wood Stove Exposure:
- ☐ Yes
- ☐ No

Daycare:
- ☐ Yes
- ☐ No

Exposure to Other Agents:
- ☐ Asbestos/Silica
- ☐ Chemicals
- ☐ Industrial Agents
- ☐ Radiation Treatments
- ☐ Other: _____________________

ALLERGY/IMMUNOLOGY HISTORY

Please describe in your own words the primary medical problem and duration of symptoms that brought you to our office:

____

____

When did your symptoms start? ____

Mark the symptomatic months: □ Jan □ Feb □ Mar □ Apr □ May □ June □ Jul □ Aug □ Sep □ Oct □ Nov □ Dec

□ Spring □ Summer □ Fall □ Winter □ All year round

Triggers:

Eye/nasal symptoms worsened by:

□ smoke □ aerosols □ dust □ perfumes □ basements □ cats □ dogs
□ cold air □ wind □ beer/wine □ temp changes □ humidity □ rain □ season changes
□ heartburn □ other: ____

Lung symptoms worsened by:

□ smoke □ aerosols □ dust □ perfumes □ basements □ cats □ dogs
□ cold air □ wind □ beer/wine □ temp changes □ humidity □ rain □ season changes
□ activity □ resp infection □ laughing □ heartburn □ aspirin products
□ other: ____

Skin symptoms worsened by:

□ heat □ exercise □ sunlight □ cold □ vibration □ water □ vibration
□ rubbing □ scratching □ wool □ cut grass □ leaves □ plants □ poison ivy/oak
□ soaps □ cosmetics □ menstrual cycle □ foods: ______________________________
□ other: ____

Skin history: (hives, rash, swelling, angioedema: skip if no skin problems):

Skin problems: □ eczema □ rash □ hives □ swelling □ itching □ dry skin

Features: Date of onset: ____________ Worse in: □ AM □ PM □ after meals □ all day

Affected areas: □ hands □ arms □ feet □ legs □ stomach □ back □ head/face

Appearance: □ red □ flat □ raised □blistery □ leaves marks/bruises

□ moves around □ stays in one spot how long does it last? __________

Current Skin Products: soap: ____________ shampoo: ______________ conditioner: ____________

detergent: ________________ fabric softener: __________________________

toothpaste: ____________________ cosmetics: ____________________________

perfumes: ______________________ any scent changes? ______________________

Stings: reactions to: □ bees □ wasps □ hornets □ fire ants □ mosquitoes □ chiggers

reaction type: □ large local reactions □ hives □ wheezing □ throat swelling □ nausea/diarrhea □ unconsciousness □ required emergency treatment

age at time of first reaction: ________

Tick bites/exposure: □ No □ Yes When did last bite occur? ______________

Anaphylaxis:

Other history of anaphylaxis? □ No □ Yes Age at time of reaction: _____ Trigger if known: ____________