

ALLERGY, ASTHMA & SINUS CENTER, P.C.

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Patient Questionnaire

Name of patient: _____ Sex M F Date of birth ____/____/____ Date seen ____/____/____

*What is bothering you the most? Nose Sinus Eyes Lungs Skin Other _____

*How long have you been having the problem(s)? few day few weeks few months 1-2yrs 2-4yrs 5-10yrs All my life

A. Nose / Sinus / Throat Symptoms:

____ Mouth breathing ____ Sneezing (some / lot) ____ Runny nose ____ Postnasal drip
____ Snoring ____ Itchy nose ____ Sniffing ____ Throat clearing
____ Loss of sense of smell ____ Burning nose ____ Dry nose ____ Scratchy throat
____ Sinus pressure (cheeks / eye are / forehead)
____ Headaches ____ Sore throat
____ Nasal stuffiness / congestion: left right both sides changes sides ____ Lump in throat
____ Sinus infection (_____ # times in the last 12 months) last sinus infection requiring antibiotics was on _____

*Nasal discharge (in the last 1-3 weeks) clear white off white light yellow deep yellow green

*Blow your nose (in the last 1-3 weeks) hardly ever 1-2x day 2-10x day 1-2x hour _____

B. Eye Symptoms:

____ Swelling of eyes ____ Itching ____ Red eyes ____ Wear contact lenses
____ Dark circles / swelling under the eyes ____ Dry sensation ____ Watering ____ Diagnosed with glaucoma

C. Ear Symptoms: ____ Popping ____ Fullness ____ Itchy ears ____ Ringing ____ Sensation of fluid/water

____ Ear infection (_____ #times in the last 6 months)

____ Tubes placed (last tubes placed _____) were adenoids removed? N / Y (When _____)

*Which month(s) are symptoms worse?

Yearlong Spring Summer Fall Winter
March April May June July August September October November

*Severity of symptoms: Mild Mild-moderate Moderate-severe Very severe

*Associate with: Loss of sleep Decreased outdoor activity

*Worsened by:

Do not know of anything Mowing the lawn Cat / dog / other animal(s) _____
Perfumes Raking leaves Outdoors Vacuuming the house Work
Smoke Weather change Humidity Change in temperature

*What has been done? Nothing Nasal Endoscopy Allergy blood test Allergy skin test
Sinus CT scan (_____) Sinus x-ray Sleep study (when _____)
Saw an ENT doctor (Dr. _____) (When _____)

*Have you been diagnosed with Hay fever / allergies Rhinitis Nasal polyps Deviated nasal septum
 Sinusitis / sinus infection Sleep apnea

*What has been done to *treat allergy / sinus* problem (s)? (Please circle)

Medications:

Alavert Allegra Allegra-D Benadryl cetirizine Clarinex Claritin Claritin-D chlorpheniramine Chlor-Trimeton clemastine desloratadine fexofenadine loratadine levocetirizine, montelukast, pseudoephedrine Singulair Sudafed Tavist Tylenol PM Xyzal Zyrtec Zyrtec-D _____

Nasal sprays:

Astepro Astelin Flonase fluticasone Nasacort NasalCrom Nasonex Omnaris Patanase Rhinocort Veramyst

Do you use: Afrin Dristan Equate Four way Sinaid Nasal Spray? When did you use it last _____

Eye drops

Artificial tears Alaway Bepreve Pataday Patanol Naphcon Restasis Vasocon Visine Zaditor steroid allergy eye drops

Antibiotics

Amoxicillin amoxicillin-clavulanic Augmentin Augmentin-ES Avelox azithromycin Bactrim Biaxin Cedax cefdinir Ceclor Cefzil cefprozil Ceftin cefuroxime cephalixin Cipro Cleocin clindamycin doxycycline erythromycin Keflex Levaquin Omnicef Sulfa Zithromax

Prednisone Medrol Dosepak Kenalog Depo Shot

Nasal surgery: septoplasty turbinectomy polypectomy sinus surgery (when _____)

Allergy shots (given every 1-3 weeks for months/years, given to help **build up** immunity)

CPAP / BiPAP (started when _____)

D. Chest Symptoms: No Yes (how may days / months / years? _____)

Chest tightness / congestion / rattling Wheezing Shortness of breath Chest pain Difficulty taking a deep breath
 Cough (___little___moderate___lots___dry___wet) Phlegm (color: ___clear___white___yellow___green)

* Do you have chest symptoms? everyday 1-2x wk 3-4x/wk few times / month few episodes / year

* How long do chest symptoms last: minutes 10 minutes to a few hours up to a few days

*When are these chest symptoms worse?

On laying down Exposure to cold air Summer / spring/ fall / winter Cat / dog/ other animal(s) _____
 On waking up Laughing Exercise / jogging / running / sports Walking fast
 Smoke / odors Vacuuming / dusting

*Do you wake up at night with?

Cough / shortness of breath / wheezing How often: everyday 1-2x week 3-4x week 1-2x month

Have chest symptoms led to: Emergency room when _____ Hospitalization When: _____

*Have you ever had?

Lung tests (pulmonary function tests) Methacholine Challenge Mannitol Challenge Test
 Chest x-rays (When : _____) Chest CT Bronchoscopy oxygen test

*Have you been **diagnosed with?**

Childhood asthma Adult asthma Cough variant asthma Exercise-induced asthma Reactive airway disease
 Emphysema / COPD
 Panic attacks Anxiety
 Pneumonia (When : _____)

*What has been done to treat your **chest** related symptom(s)? (Please circle)

- Cough Medications: Cardec-DM Histussin HC Histinex Tussionex Phenergan with Codeine Antibiotics
 Asthma inhalers / medications

Rescue inhaler: albuterol Atrovent Combivent ProAir Proventil Ventolin Maxair Xopenex
 How often everyday 1-2x day 3-4x day 1-2x month 3-4x month other: _____

Rescue nebulizer: Albuterol 0.21%, 0.42%, 0.83%, Atrovent AccuNeb DuoNeb ipratropium Xopenex neb 0.31 0.63 1.25mg
 How often everyday 1-2x day 3-4x day 1-2x month 3-4x month other: _____

Advair Diskus 100 / 250 / 500 Advair HFA 45 115 230 Alvesco 80 160 Asmanex 110 / 220 Dulera 100 / 200
 Flovent MDI 44 / 110 / 220 Flovent Diskus 50 / 100 / 250 Pulmicort Flexhaler 90 / 180
 Pulmicort Respules 0.25 0.5 1.0 mg Q-Var 40 / 80 Symbicort 80 / 160

Accolate Singulair montelukast, Zflo Theophylline
 Serevent Diskus Foradil Aerolizer Spiriva Brovana
 Orapred Pediapred Prelone Prednisolone Prednisone Medrol Dosepak _____

- * Side effects of asthma / COPD medication(s) None _____
 * Currently on: Oxygen CPAP / BiPAP (For how long _____)

E. Systemic Symptoms:

- Fever Sweating Chills Lack of energy Loss of appetite
 Do not feel fresh on waking up Fall asleep easy during the day
 Weight gain (last 1 year) _____ lbs Weight loss (Last 1 year) _____ lbs

F. Gastrointestinal Symptoms:

*Do you have: Heartburn Acid in the throat Food getting stuck in the upper chest or neck
 *How often: Rarely everyday 2-3x week 2-4x month

* Do you wake up at night with heartburn? never everyday 1-2x week 1-2x month
 *Do you have? Nausea Vomiting Loose stools Abdominal pain Blood in the stools

*Have you been **diagnosed with**?
 Reflux / GERD Hiatal hernia Irritable bowel Peptic ulcer Crohn's
 Ulcerative colitis Eosinophilic esophagitis Hepatitis B / C
 *Have you undergone? Barium swallow Upper GI Endoscopy Colonoscopy PH probe Nissan fundoplication

*What has been done to treat your GI symptom(s)? (Please circle)

AcipHex Dexilant lansoprazole omeprazole Prilosec Prevacid Protonix Pantoprazole Nexium Zegerid
 Ranitidine Axid cimetidine famotidine Tagamet Pepcid Zantac

G. Heart Symptoms:

- Irregular heart rate Skipped heartbeat Chest pain
 High blood pressure Elevated cholesterol
 Coronary artery disease Heart attack Angina Atrial fib CHF Mitral valve prolapse

*Have you seen a cardiologist? Y / N

- * What has been done? EKG ECHO Stress test Treadmill Nuclear scan Angiogram Coronary bypass
 CABG Angioplasty Stent placed Pacemaker

H. Urinary Symptoms:

- Diagnosed with prostate enlargement, prostate / bladder / kidney cancer, kidney stones

I. Joint Related Symptoms:

- Swollen, painful joints, aches & pains in joints, stiffness Diagnosed with rheumatoid, lupus, osteoarthritis, fibromyalgia

J. Skin Symptoms:

- Hives welt Swelling of lip / eyes / face /tongue / hands Rash Eczema
- Itching (little bit, moderate degree, lot of itching)

- For years For months Few weeks Few days

- Every single day Comes and goes Lasts for _____ hours or 1 /2 / ...days
- All over Face / chest/ abdomen/ arms/ forearm/ hands/ thighs/ legs/ behind knees / front of elbows
- ___ Heat ___ Cold ___ Vibration ___ Sun ___ Pressure ___ Exercise ___ Water ___ Scratching the skin
- ___ Food ___ Coloring agent
- ___ Aspirin, Motrin, ibuprofen ___ Codeine or related drugs

*What has been done to treat **skin** symptom(s)?

- Skin biopsy Blood work Seen a dermatologist Seen regular doctor

- Over the counter creams: hydrocortisone 1% cream _____
- Prescription steroid creams (triamcinolone, flunisolide, Temovate, Desonide.....)
- Protopic Elidel
- Allegra Atarax Benadryl Claritin Clarinex cetirizine Doxepin fexofenadine hydroxyzine levocetirizine
- loratadine Singulair Xyzal Zyrtec _____
- ranitidine Tagamet Zantac
- Medrol dose pack steroid injection prednisone tablets

K. Brain Symptoms:

- Have you been diagnosed with Migraine, chronic tension headaches, stroke, epilepsy, seizures
- Did you have? CT scan of brain / CT of the sinuses / MRI brain, seen a neurologist
- Headaches (How long have you been having them? _____ months / years)(Are they worse recently? YES NO
- ___ Forehead ___ Top of head ___ Side of head ___ Back of head
- ___ eye/behind eye ___ Between eyes ___ Over cheeks

- Always right sided Always left sided Changes sides Both sided
- 1-2 times a month 1-2 times a week 3-4 times a week Almost daily
- Last for ___ 1-3 hours ___ 4-12 hrs ___ 13-24 hrs ___ 1-3 days ___ more than 3 days
- Very severe Severe Moderately severe Mild Varies
- Throbbing, pulsating Pressure Stabbing _____

Associated with

- Sensitivity to light Sensitivity to sound Nausea Vomiting

Worsened by

- Movement / bending the head Before during or after menstrual period
- Sleep deprivation / hunger Aged cheese Red wine Others _____

Made better with

- Sleep Dark room Coffee Pop
- Tylenol Tylenol Sinus Tylenol Allergy OTC Allergy/sinus tablets
- Motrin ibuprofen Aleve Naproxen Excedrin Excedrin Migraine
- Amerge Axert Frova Imitrex Maxalt Migranal Relpax Sumavel Treximet Zomig
- Tylenol with codeine Cafergot Darvocet hydrocodone Fiorinal Fioricet

Take these medications: <input type="checkbox"/> daily <input type="checkbox"/> few times a week <input type="checkbox"/> few times a month

L. Allergy Symptoms: reaction to foods: Sea foods, tree nuts, peanuts, milk, egg, _____
_____ Banana apple watermelon cherries peach pear _____

(none) Reaction after stung by bees, wasp, hornet, and yellow jacket
 Local swelling only
 Anaphylaxis, other severe reactions _____

M. Blood/cancer: Low hemoglobin, excessive bruising, bleeding tendency, cancer: breast/uterus/cervix/colon/prostate.....
(none)

N. Endocrine: Under active or overactive thyroid Thyroid supplements (last blood test for thyroid?.....)
(none) Diagnosed with diabetes

O. Psychiatric: Feel depressed, not able to enjoy the usual things of life? Anxious?
(none) Diagnosed with depression, anxiety, bipolar disorder, panic attacks, ADD/ADHD _____
 On antidepressants, anxiety medications _____

P. Reproductive:
 Do you have excessive menstrual blood loss? YES NO
 Last menstrual period was on _____
 Taking birth control pills for _____ months/ years
 Diagnosed with infertility, endometriosis, fibroid, pelvic inflammation, cervical / uterine, prostate cancer

Current list of medications:

- 1. 2. 3.
- 4. 5. 6.
- 7. 8. 9.
- 10.

Allergies to medications: None _____

Past history:

- Broke nose Head injury Sinus surgery / septoplasty / turbinectomy / nasal polyps / sinus polyps removed
- Tonsil taken out (age.....) Adenoids taken out (age.....) Tubes in ears
- Surgery for appendix, gallbladder, hysterectomy, carpal tunnel, skin cancer, breast cancer, thyroid surgery,
Coronary bypass, angioplasty _____
- Admitted to hospital for _____
- Diagnosed with childhood or adult onset asthma eczema as a child /adult allergies
- Diagnosed with -pneumonia (when was the last time? _____)
-blood clot in lung or leg
-cancer (which part of body _____) [treated with chemo / radiation / surgery]
-heart trouble
-Hepatitis 'B' or 'C'
- Received pneumonia vaccine? YES NO [when? _____]

Less than 10 yrs old: Birth weight _____ lbs _____ premature _____ full term

Social history:

- Never smoked
 Smoked cigarette 1/2 1 1 1/2 2 packs/day Smoked for a few months few years 10 20 yrs 30 yrs 40 yrs
 Stopped smoking _____ years ago Still Smoke: Yes / No
 Single Married Divorced Widow (er) No children Have children (ages) _____

Job / Travel history:

- Kid Student in school / college _____ grade _____
 What is your job? _____ Work at current job for _____ months / years
 Are symptoms worse at work? YES NO

Environment:

- House Apartment Mobile home Duplex
 For few months 1-2 years Many years
 Natural gas Propane Wood heat Electric heat Space heat
 No air conditioning Central A.C. Window A.C.
 Mostly carpet Mostly wood floors Carpet in bedroom Wood floor in bedroom

Building is very old
 old
 relatively

- No indoor smoker Who smokes in the house? _____
 No feather pillow /comforter Feather pillow / Down comforter Do not know
 Regular mattress Waterbed
 No indoor/ outdoor pet / animals

Cockroaches
 Yes / No

Indoor Cat Dog Bird Guinea pig Hamster Gerbil Ferret
 Outdoor Cat Dog Horse Cattle Hogs Rabbit

Does any close friend or relative where you visit have Cats / dogs _____

Family history:

	Asthma	Allergies	Eczema	Migraine
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Sister/brother	____/____	____/____	____/____	____/____
Son/daughter	____/____	____/____	____/____	____/____
Grandparents	_____	_____	_____	_____
Uncle/Aunt	____/____	____/____	____/____	____/____
Cousin	_____	_____	_____	_____

Spouse's job _____ Mother's job _____ Father's job _____