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

Nose / Sinus / Throat Symptoms:

_____Mouth breathing _____Sneezing (some / lot) _____Runny nose _____Postnasal drip
_____Snoring _____Itchy nose _____Sniffling _____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 □_____

Eye Symptoms:

_____Swelling of eyes _____Itching _____Red eyes _____Wear contact lenses
_____Dark circles / swelling under the eyes _____Dry sensation _____Watering _____Diagnosed with glaucoma

Ear Symptoms: ___Popping ___Fullness ___ Itchy ears _____Ringing _____Sensation of fluid/water
_____Ear infection (_____#times in the last 6 months)

*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 □Can't 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 (Who: _____ __) (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:**

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

□ **Nasal sprays:** Astelin Flonase fluticasone Nasacort NasalCrom Nasonex Patanase Rhinocort

*Do you use Afrin, Dristan, Oxymetazoline, Equate, Four way, Sinaid nasal spray? When did you use it last? _____

□ **Eye drops:** Artificial tears Pataday Patanol Restasis Visine Zaditor OTC eye drops_____

□ **Antibiotics**: Amoxicillin amoxicillin-clavulanic Augmentin azithromycin Bactrim Biaxin cefdinir Ceclor Cefzil cefprozil Ceftin cefuroxime cephalexin Cipro Cleocin clindamycin doxycycline erythromycin Keflex Levaquin Omnicef Sulfa Zithromax

□Steroids: Prednisone Medrol Dosepak Kenalog _____

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

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

□ CPAP / BiPAP (date started:_____)

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)

*Are you having asthma attacks?_____

* 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** during the 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

□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 □Bronchitis □Panic attacks □Anxiety □Pneumonia/Croup (When :_____)

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

□Asthma inhalers / medications

Rescue **INHALER**: Albuterol Combivent ProAir Proventil Ventolin Xopenex

How often: □everyday □1-2x day □3-4x day □1-2x month □3-4x month □other:_____

Rescue **NEBULIZER**: Albuterol Atrovent DuoNeb Ipratropium Other_____

Advair Diskus 100 / 250 / 500 Advair HFA 45 115 230 Alvesco Asmanex Dulera 100 / 200 Flovent MDI Flovent Diskus Pulmicort Flexhaler Pulmicort Respules Q-Var 40 / 80 Symbicort 80 / 160 Trilegy Wixela Inhub

Singulair/Montelukast Spiriva Brovana Incruse Seebri Neohaler Tudorza Arcapta Striverdi Duaklir Pressair

Pediapred Prelone Prednisolone Prednisone Medrol Dosepak _____

*Currently on: □Oxygen _____L □CPAP / BiPAP (For how long_____)

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

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 □Hepatitis B/C

□Ulcerative colitis □Eosinophilic esophagitis □Gallbladder disease □Helilobacter Pylori

**Have you undergone/had*? □Barium swallow □Upper GI □Colonoscopy/EGD/Upper endoscopy □Stool or blood testing

Blood test for celiac/gluten intolerance? Y / N _____

Esoophageal dilation/stretching? Y / N _____

□Nissan fundoplication

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

AcipHex Dexilant Lansoprazole Omeprazole Prilosec Prevacid Protonix Pantoprazole Nexium Cimetidine Famotidine Tagamet Pepcid Antacid _____

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 undergone? □EKG □ECHO □Stress test □Treadmill test □Nuclear scan □Angiogram □Coronary bypass □CABG □Angioplasty □Stent placed □Pacemaker

Urinary Symptoms: □Diagnosed with prostate enlargement, prostate / bladder / kidney cancer or kidney stones

Joint Related Symptoms: □Swollen, painful joints, aches & pains in joints, stiffness

□ Diagnosed with rheumatoid, lupus, osteoarthritis, fibromyalgia

Skin Symptoms:

□Hives □Welts □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 / days
□All over □Face / chest/ abdomen/ arms/ forearm/ hands/ thighs/ legs/ behind knees / front of elbows

*What makes it worse? ___*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 □Patch Testing □Blood work □Seen a dermatologist □Seen regular doctor

□Over the counter creams: hydrocortisone 1% cream_____
□Prescription steroid creams (triamcinolone, flunisolide, Temovate, Desonide…….. ……)
□Protopic □Elidel □Eucrisa
□*Allegra* □*Atarax* □*Benadryl* □*Claritin* □*Clarinex* □*cetirizine* □*Doxepin* □*fexofenadine* □*hydroxyzine* □*levocetirizine*
□*loratadine* □*Singulair* □*Xyzal* □*Zyrtec* □*Famotidine* _____
□ Medrol dose pack □Steroid injection □Prednisone tablets

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 of 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
□*Imitrex* □*Maxalt* □*Zomig* □*Tylenol with codeine* □*Darvocet* □*hydrocodone* □*Other* _____

*How often are you using these to relieve pain? _____

Allergy Symptoms: □ Reaction to foods: YES / NO

□Seafoods, tree nuts, peanuts, milk, egg, or other:_____

_____

_____

_____

□Banana, apple, watermelon, cherries, peaches, pears or other: _____

_____

_____

□Reaction after stung by bees, wasp, hornet, and yellow jacket □Local swelling only □Serious reaction

□Describe Symptoms: _____

Blood/cancer: □Low hemoglobin, excessive bruising, bleeding tendency

□Cancer: breast/uterus/cervix/colon/prostate……

Endocrine: □Under active thyroid □ Overactive thyroid □Diagnosed with diabetes

Psychiatric: □Feel depressed, not able to enjoy the usual things of life? □Anxious?

□Diagnosed with depression, anxiety, bipolar disorder, panic attacks, ADD/ADHD/PTSD:_____

□On antidepressants and/or anxiety medications:_____

Reproductive: □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.	**11.**	**12.**

Allergies to medications: □None □_____

Please list all your medical diagnoses: _____

_____

_____

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, breast cancer, thyroid, coronary bypass, angioplasty, other: _____

□Admitted to hospital for/when _____

□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 □HIV infection

***Less than* 10 yrs old**: Birth weight_____lbs _____premature _____full term

Social history: □Never smoked □Smoke cigarettes □Smoke Marijuana
□Few cigarettes/day □1/4 pack/day □1/2 pack/day □1 pack/day □2 packs/day
□Smoked for a few months ___few years ___10yrs ___20 yrs ___30 yrs ___ 40 yrs
□Stopped smoking _____years ago

□Single □Live with Significant Other □ Married □Divorce □Widow (er) □No children □Have children (ages) _____

Job / Travel history: □Kid □Grade _____ □Student in school / college _____
□What is your job?_____ □Worked at current job for _____months / years

Environment: □House □Apartment □Mobile home □Duplex
For: □few months □1-2 years □Many years

How old is your building?

___ New

___ Old

___ Very Old

□Natural gas □Propane □Wood heat □Electric heat □Space heat
□Mostly carpet □Mostly wood floors □Carpet in bedroom □Wood floor in bedroom

□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
Indoor ___Cat ___ Dog ___ Bird ___ Guinea pig ___ Hamster ___ Gerbil ___ Ferret
Outdoor ___ Cat ___ Dog___ Horse ___ Cattle ___ Hogs ___ Rabbit

Cockroaches?

Y / N

Asian Beetles or Lady bugs in the house?

Y / N

*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(maternal/paternal)	___/___	___/___	___/___	___/___
Uncle/Aunt(maternal/paternal)	___/___	___/___	___/___	___/___
Cousin	_____	_____	_____	_____

_____ _____ _____
Spouse's Job Mother's Job Father's Job