# Allergy & Asthma Specialists, LTD.

Gary B. Moss, MD • Craig Koenig, MD • Gregory Pendell, MD
Lisa Deafenbaugh, PA-BC • June Raehl, FNP-BC • Kim Pham, NP-C

## New Patient Questionnaire

**Patient's Name:**
**Date of Birth:**
**Patient's Primary Care Physician:**
**PCP's Phone Number:**
**PCP's Address:**
**Other Physician's Involved in Patient's Care:**

**Preferred Pharmacy/Address:**

**Please briefly describe the main reason for the appointment:**

### Medications: Please provide a list of all current medications (prescription and over the counter medications)

| Medication | Strength | Frequency |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

### Known Drug Allergies: ☐ No known drug allergies

| Drug | Reaction |
|---|---|
| | |
| | |
| | |
| | |

### Past Medical History: ☐ No past medical history

| | | |
|---|---|---|
| ☐ Asthma | ☐ Stroke | ☐ Anxiety |
| ☐ Eczema | ☐ Thyroid disease | ☐ Depression |
| ☐ COPD | ☐ Arthritis | ☐ Infections, recurring |
| ☐ Allergic rhinitis | ☐ Diabetes | ☐ Latex allergy |
| ☐ Hives | ☐ Reflux (GERD) | ☐ Bee/stinging insect allergy |
| ☐ High blood pressure | ☐ Irritable bowel | ☐ Food allergy |
| ☐ High cholesterol | ☐ Celiac disease | ☐ Other/Explain: |
| ☐ Heart disease | ☐ Cancer | |

## Surgical History: ☐ No surgical history

| | | |
|---|---|---|
| | | |
| | | |
| | | |

## Social History: Please check all that apply to the patient's living situation

| | |
|---|---|
| **Occupation** | ☐Full time ☐Part time ☐Retired ☐Not currently working ☐Works from home ☐N/A |
| **Student** | ☐Full time ☐Part time ☐N/A Name of school/daycare: |
| **Occupational Exposure** | ☐Dust ☐Chemicals ☐Air contaminants ☐Cigarette smoke<br>☐Symptoms get better at work/school ☐Symptoms get better at home |
| **Smoking History** | ☐Never smoked ☐Previous smoker, Started:_____Stopped:_____<br>☐Current smoker: Pack(s) per day:_____ |
| **Alcohol Use** | ☐Never ☐Rarely ☐Socially ☐Daily |

## Family History (Immediate family only) ☐No family history known ☐Adopted

| **Number of:** | | | Sisters:____ | Brothers:____ | Sons:____ | Daughters:____ |
|---|---|---|---|---|---|---|
| **Allergic Rhinitis** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Asthma** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Eczema** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Hives** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Swelling** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Bee Allergy** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Food Allergy** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Drug Allergy** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Latex Allergy** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Cancer** | ☐ Father | ☐ Mother | ☐ Sister(s) | ☐ Brother(s) | ☐ Son(s) | ☐ Daughter(s) |
| **Additional family history:** | | | | | | |

## Environmental History (Please check all that apply to the patient's living situation):

| | |
|---|---|
| **Home** | ☐House ☐Condo ☐Townhome ☐Apartment ☐Mobile home ☐Dorm ☐Farm |
| | How old is the home? How long has the patient lived in the home? |
| **Foundation** | ☐Slab ☐Crawl space* ☐Basement *If crawl space, is it sealed? ☐Yes ☐No |
| **Heating** | ☐Central ☐Baseboard ☐Radiator ☐Wood stove ☐Space heater |
| **Cooling** | ☐Central ☐Window Units ☐Open windows |
| **Air Quality** | Air filters are changed/cleaned: ☐Monthly ☐Every 3 months ☐Every 6 months ☐Yearly |
| | Please check all that apply: ☐Humidifiers ☐Dehumidifiers ☐HEPA filters ☐Air purifiers |
| **Smoke Exposure** | ☐ No exposure to smoke ☐Patient smokes ☐Exposed to smoke in environment |
| **Pets/Animal Exposure** | ☐None ☐Dogs ☐Cats ☐Birds ☐Rabbits ☐Horses ☐Goats ☐Mice/rats ☐Guinea pigs ☐Hamsters |
| **Pests Issues** | ☐ None ☐Insects ☐Cockroaches ☐Mice ☐Rodents ☐Extermination performed regularly |
| **Mold Issues** | ☐None ☐Current ☐Previous history |
| **Indoor Plants** | ☐ None ☐ A few ☐ Many |
| **Linens** | Washed: ☐Every few days ☐ Weekly ☐Every 2 weeks ☐ Monthly ☐ Infrequently |
| | Water Temperature: ☐Hot ☐Cold ☐ Warm |
| **Pillows** | ☐Feather ☐Synthetic ☐Dust mite covers |
| **Comforter/Mattress** | ☐Feather ☐Synthetic ☐Dust mite covers |
| **Flooring** | ☐Carpet ☐Wood ☐Tile |
| **Overall Cleanliness** | ☐Clean ☐Dusty ☐Neat ☐Cluttered |

## Review of Systems: Current symptoms/recurring problems

| | |
|---|---|
| **Constitutional** | □Fever □Chills □Decrease appetite □Fatigue □Night Sweats |
| **Eyes** | □Itchy □Redness □Watery discharge □Dry □Gritty □Worsening vision<br>□Swelling of eyelid □Wears glasses □Wears contacts |
| **Ears** | □Itchy □Fullness □Pressure □Popping □Ringing □Earaches □Vertigo □Hearing loss |
| **Nose** | □Itching □Discharge □Sneezing □Stuffy □Nose bleeds □Snoring<br>□Loss of smell □Mouth breathing |
| **Throat** | □Itchy □Postnasal drip □Constantly clearing throat □Sore throat □Hoarseness<br>□Difficulty swallowing □Mouth sores □Mouth dryness □Loss of taste |
| **Head/Neck** | □Headache □Sinus pain □Headaches during certain seasons □Sinus infections<br>□Swollen neck glands |
| **Respiratory** | □Difficulty breathing □Wheezing □Chest tightness □Cough □Sleep apnea<br>□Breathing interrupts sleep □Wheezing with exercise |
| **Cardiovascular** | □Chest pain □Palpitations □Heart murmur □Dizziness |
| **Gastrointestinal** | □Heart burn □Abdominal discomfort □Nausea □Vomiting □Bloating<br>□Diarrhea □Constipation |
| **Genitourinary** | □Decreased urine output □Feeling dehydrated □Urinary incontinence<br>□Pain during urination □Frequent awakenings to urinate |
| **Psychiatric** | □Anxiety □Depression □Suicidal thoughts |
| **Neurological** | □Fainting □Tingling □Numbness □Paralysis □Confusion □Difficulty with balance<br>□Limb weakness □Memory loss □Abnormality of walk |
| **Musculoskeletal** | □Muscle aches □Joint pain □Limb swelling |
| **Endocrine** | □Thyroid disorders □Diabetes □Increased thirst □Increased urination □Heat intolerance<br>□Cold intolerance □Excessive sweating □Growth and development |
| **Skin** | □Itching □Eczema □Hives □Swelling □Rash □Skin lesions □Contact dermatitis □Dry |
| **Hematology** | □Easy bruising □Easy bleeding □Anemia |

**Additional pertinent information:** _____

_____

_____

_____

_____

_____

**Signature of person filling out form:** _____

**Print Patient Name:** _____ **Patient DOB:** _____ **Date:** _____