

Name: _____

Allergy & Asthma Consultants 1

Occupation: _____

of Rockland and Bergen

Date: _____

John V. Bosso, M.D., FAAAAI, FAAAAI

Referred by: _____

Lourdes B. de Asis, M.D., FACP, FAAAAI

ALLERGY, ASTHMA, AND IMMUNOLOGY REVIEW

Antihistamine medications (**Claritin, Clarinex, Zyrtec, Allegra, Benadryl, Atarax, Contac, Tylenol PM or Allergy, etc.**) may interfere with skin tests for specific allergies; each antihistamine has a specific time frame for which it needs to be discontinued prior to skin testing. The office nursing staff can assist you with this.

Please answer all questions on all 6 pages to the best of your ability. Base your answers on your own observations and not on what you have been told by others or what you may have presumed on the basis of previous allergy tests. Complete the questionnaire before you see the physician as the information will organize your thinking and facilitate understanding of your case. If a question does not apply, you may leave it blank.

I. Describe in your own words your problem(s) which might reflect an allergic/exaggerated reaction _____

II. Please put a check and complete the blanks which apply to your symptoms:

	<u>Present Problem</u>	<u>Past Problem</u>	<u>MD Comment:</u>
A. Eye Symptoms (Wears contact lenses__)			
Itching	--	--	
Watering	--	--	
Redness	--	--	
Swelling	--	--	
Burning	--	--	
Dryness	--	--	
Foreign Body Sensation	--	--	
B. Symptoms in the upper respiratory tract (nose, sinuses, throat, Eustachian tubes, voice box:)			
Itching	--	--	
Sneezing	--	--	
Congestion	--	--	
Headache	--	--	
Obstruction	--	--	
Drainage	--	--	
Soreness	--	--	
Dryness	--	--	
Hoarseness	--	--	
Hearing Loss	--	--	
Polyps	--	--	
Impaired Smell/ Taste	--	--	
Snoring	--	--	
C. Symptoms in the lower respiratory tract (windpipe, bronchi, lungs):			
Itching	--	--	
Coughing	--	--	
Sputum production	--	--	
Tightness- Congestion	--	--	
Wheezing	--	--	
Shortness of Breath	--	--	
Pain	--	--	

Name: _____

**Allergy & Asthma Consultants 2
of Rockland and Bergen**

How many ordinary colds and "flu" illnesses have you had in the last year? # _____

How many colds and "flu" on average in the last 5 years? # _____ / yr.

What proportion (0, 10, 25, 50, 75, 90, 100%) of these are complicated by:

Otitis- earache, decreased hearing ___%, Sinusitis- pressure discolored drainage- ___%;

Bronchitis- cough with discolored sputum ___%; Asthma- chest tightness,

Wheeziness ___%

What proportion require antibiotics for resolution? _____%

Which antibiotic(s) work(s) best for you? _____

D. Symptoms in the stomach and digestive system which you suspect might be allergic:

	<u>Present Problem</u>	<u>Past Problem</u>	<u>MD Comment:</u>
	Pain or difficulty swallowing	___	___
	Nausea or vomiting	___	___
	Heartburn/ Indigestion	___	___
	Abdominal cramping	___	___
	Constipation/ Diarrhea	___	___
E.	Hives/ Giant Swelling?	___	___
F.	Eczema?	___	___
G.	Skin reaction to poison ivy/ oak, Metals, chemicals, or cosmetics? (Circle)	___	___
H.	Reaction to bee, hornet, wasp, Yellow jacket, or other stinging Insect bite? (Circle)	___	___
I.	Reaction to immunization?	___	___
J.	Reaction(s) to drugs?	___	___
	Penicillin (Date/ year last taken)	___	___
	Aspirin (date/ year last taken)	___	___
	Sulfa	___	___
	Nose drops/ sprays	___	___
	Sedatives	___	___
	Pain relievers	___	___
	Hormones	___	___
	Antihistamines	___	___
	Cortisone	___	___
	X-ray dye	___	___
	Others _____	___	___
K.	Latex reactions? (gloves, balloons,etc.)	___	___

Name: _____

**Allergy & Asthma Consultants 3
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III. Check or complete the correct answers to describe your residence and workplace.

Type of dwelling:

___ House ___ Apartment ___ Condominium ___ Dormitory ___ Mobile/
Motorhome

Location (town): _____

Age of Dwelling: ___ years Years of occupancy ___

Obvious mildew/ mold ___ Roaches _____

Central: ___ Heating ___ Air Conditioning ___ Humidifier ___ Filter type _____

Heating Type: _____

Bedroom: ___ Heating ___ Air Conditioning ___ Humidifier ___

Filter-type _____

Bedroom Floor Coverings: ___ Carpet ___ Wood ___ Cement ___ Linoleum/tile

Bed mattress: ___ Conventional ___ Water ___ Age in years _____

___ Allergen encasement

Pillows: ___ Feather/ Down ___ Foam Rubber ___ Dacron/ synthetic Age in
years: _____ Allergen encasement

Indoor Animals: ___ Cat ___ Dog ___ Bird ___ Other _____

Outdoor Animals: ___ Cat ___ Dog ___ Bird ___ Other _____

Smoker (s) in residence ___ Relationship: _____

Describe briefly your workplace/ school environment:

IV. Please check appropriate symptoms aggravated or precipitated by exposure during:

Eyes Nose/ Sinuses/ Ears Chest Digestive Hives/Swelling Eczema

Spring

(March to May) _ _ _ _ _

Summer

(June to Aug) _ _ _ _ _

Autumn

(Sept to Nov) _ _ _ _ _

Winter

(Dec to Feb) _ _ _ _ _

Sleep

On awakening _ _ _ _ _

At work

At play _ _ _ _ _

Vacation

Exercise _ _ _ _ _

Emotional upset

(laughter, anger) _ _ _ _ _

Weather changes _ _ _ _ _

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V. Complete the blanks or check the characteristics to describe yourself: (Social History)

Single Married Divorced Widowed

of days of work/ school missed in past year? _____ # of practitioners seen in past year? _____

of emergency room/ urgent care visits in past year? _____ # of days in hospital in past year? _____

Aerobic exercise type? _____ Hours per week? _____

Average hours of sleep per night when well? _____ when ill? _____

Packs of cigarettes smoked per day? _____ other tobacco per week? _____

If former smoker: years quit? _____ Smoked total # years _____ Average #packs/day _____

Bottles of beer per week _____ #alcoholic drinks per week _____

Hobbies _____

Drug Use: Never If Yes; in past current Type/ frequency:

Tendency to worry/ anxiety/ panic: strong average little

Tendency to depression strong average little

VI. Family History of Allergy / Asthma

	Eyes	Nose/ Sinuses	Chest (asthma)	Digestive	Hives/ Swelling
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VII. Treatment

	Received	Helpful	Side Effects
Education	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antihistamine by mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decongestants by mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal sprays/ drops	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral bronchodilators	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhaled bronchial medications	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pollen, mold, dust injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids (Circle: nose/ pills/ Bronchial/ injection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food elimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VIII. Year of last immunization for influenza? _____ pneumonia? _____ tetanus? _____

