Name: ____________________

Occupation: ____________________

Date: ______________

Referred by: ____________________

Allergy & Asthma Consultants
of Rockland and Bergen
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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:

	Present Problem	Past Problem	MD Comment:
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	☐	☐	

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:

	Present Problem	Past Problem	MD Comment:
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.)	☐	☐	

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	☐	☐	☐	☐	☐	☐

Please check appropriate symptoms aggravated or precipitated by exposure during:

	Eyes	Nose/ Sinuses/ Ears	Chest	Digestive	Hives/Swelling	Eczema
Dampness	☐	☐	☐	☐	☐	☐
Heat	☐	☐	☐	☐	☐	☐
Cold	☐	☐	☐	☐	☐	☐
Air Conditioning	☐	☐	☐	☐	☐	☐
Sunlight	☐	☐	☐	☐	☐	☐
Irritant fumes/ Aerosols/ sprays	☐	☐	☐	☐	☐	☐
Smog	☐	☐	☐	☐	☐	☐
Cosmetics/ Perfumes	☐	☐	☐	☐	☐	☐
Tobacco smoke	☐	☐	☐	☐	☐	☐
Newsprint	☐	☐	☐	☐	☐	☐
House dust	☐	☐	☐	☐	☐	☐
Cut grass	☐	☐	☐	☐	☐	☐
Cats	☐	☐	☐	☐	☐	☐
Dogs	☐	☐	☐	☐	☐	☐
Birds/ feathers	☐	☐	☐	☐	☐	☐
Other animals: ____________	☐	☐	☐	☐	☐	☐
Egg	☐	☐	☐	☐	☐	☐
Milk/ dairy	☐	☐	☐	☐	☐	☐
Wheat	☐	☐	☐	☐	☐	☐
Soy/soy products	☐	☐	☐	☐	☐	☐
Peanut/ Other nuts:____	☐	☐	☐	☐	☐	☐
Shrimp/ Lobster, other: ____________	☐	☐	☐	☐	☐	☐
Fish	☐	☐	☐	☐	☐	☐
Meats (beef/ Pork, other____)	☐	☐	☐	☐	☐	☐
Dried Fruits	☐	☐	☐	☐	☐	☐
Restaurant meals	☐	☐	☐	☐	☐	☐
Beer/ wine	☐	☐	☐	☐	☐	☐
Spices________	☐	☐	☐	☐	☐	☐
Other foods: ____________	☐	☐	☐	☐	☐	☐
Menstrual cycle	☐	☐	☐	☐	☐	☐

Name: ____________________

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	Eczema
Mother	☐	☐	☐	☐	☐	☐
Father	☐	☐	☐	☐	☐	☐
Siblings	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐

VII. Treatment	Received	Helpful	Side Effects
Education	☐	☐	☐
Antihistamine by mouth	☐	☐	☐
Decongestants by mouth	☐	☐	☐
Nasal sprays/ drops	☐	☐	☐
Oral bronchodilators	☐	☐	☐
Inhaled bronchial medications	☐	☐	☐
Antibiotics	☐	☐	☐
Pollen, mold, dust injections	☐	☐	☐
Steroids (Circle: nose/ pills/ Bronchial/ injection)	☐	☐	☐
Food elimination	☐	☐	☐
Behavior modification	☐	☐	☐
Other______________	☐	☐	☐

VIII. Year of last immunization for influenza? ______pneumonia?_____ tetanus? _______

Name: ____________________________

Date: ____________________________

MEDICAL HISTORY/ SYSTEMS REVIEW:

Have you ever had any of the following Problems? (Circle No or Yes)

Diabetes--------------------No Yes
Thyroid problem----------No Yes
Heart Murmurs------------No Yes
High Blood Pressure------No Yes
High cholesterol-----------No Yes
Heart Trouble------------- No Yes
Cancer----------------------No Yes
Arthritis/ Gout-------------No Yes
Convulsions----------------No Yes
Bleeding Tendency--------No Yes
Liver problems/Hepatitis-No Yes
Neurological Disease-----No Yes
Kidney Problems----------No Yes

Tuberculosis/ PPD Positive----------No Yes
Cataracts / Glaucoma ---------------- No Yes
Blood Diseases------------------------- No Yes
Osteoporosis/ Low Bone Density-- No Yes
Depression/ Anxiety/ Panic ----------No Yes
Previous Hospitalizations/ Surgeries/ Serious injury (When?)

____

____

____

____

Any Other Medical Conditions you have received treatment for?

____

____

Medications:

Please list all the prescriptions, over the counter medications, vitamins/ dietary and herbal supplements you are currently taking (include nasal sprays, inhalers, eye drops, and skin creams):

Name of Medicine	Dose	Frequency (e.g. daily, 2x/d)

FAMILY MEDICAL HISTORY:

Relative	Age	Illness	If Deceased, Cause of death
Father			
Mother			
Siblings			
Children			

I certify that the above information is complete and accurate.

Patient's Signature: ______________________________ Date: __________

I certify that I have reviewed the above information with the patient.

Physician's Signature: ______________________________ Date: __________