

Allergy & Asthma Center

of Southern Oregon, PC

Edward M. Kerwin, MD Kevin W. Parks, MD

Jennifer K. Milligan, PA-C Jaleh Ostovar, FNP-C

Appointments 1-888-558-1003 Fax (541) 857-4499

New Patient Questionnaire

Name: _____ Phone: _____ Birthdate: _____ Age: _____ M F Today's Date: _____

◆Medical History: (Circle or Check all that Apply)

| | | | |
|-------------------------|---------------------------------|-----------------------------|--------------------------|
| Chronic Skin Disease | Asthma or Emphysema | Gastric Reflux (heart burn) | Depression |
| Headaches | Other Lung Disease | Intestinal Problems | Anxiety |
| Seizures or Strokes | High Blood Pressure | Diabetes | Chronic Fatigue Syndrome |
| Glaucoma | Heart Disease | Thyroid Problems | Fibromyalgia |
| Ear Tubes or Surgery | Do you take a Beta Blocker? Y N | Hepatitis or Jaundice | |
| Nasal Polyps or Surgery | Other Conditions: _____ | | |

◆Current Medical Symptoms: (Circle or Check all that Apply)

| | | | | | |
|------------------|---------------|------------------|----------------------|-----------|----------------|
| Nasal Congestion | Itchy Eyes | Day Cough | Asthma or W/Exercise | Eczema | Headache |
| Post Nasal Drip | Watery Eyes | Night Cough | Wheezing | Skin Rash | Snoring |
| Sneezing | Reddened Eyes | Productive Cough | Shortness of Breath | Hives | Sleep Problems |

Triggers for Symptoms: (Circle all that Apply) Dust Trees Grasses Weeds Pets Molds/Mildew Smoke Odors Perfumes Pollution

Months with Symptoms: (Circle all that Apply) **Jan Feb March April May June July Aug Sept Oct Nov Dec**

◆Family History: (Draw a line between the condition and the family member)

| | | | | | | |
|--------|-----------|---------|--------|--------------|-------------------------------------------|------------------------|
| Asthma | Hay Fever | Eczema | Hives | Food Allergy | Other Allergy Conditions in Family: _____ | |
| Mother | Father | Brother | Sister | Son | Daughter | Other Relatives: _____ |

◆Environmental History: (Circle most bothersome months) **Jan Feb March April May June July Aug Sept Oct Nov Dec**

Lived in present home: #yrs _____ Age of home: _____ Location: _____ Moved to Oregon (What Year) _____

In what geographic area have you spent most of your life? _____

Home Conditions: (Circle all that Apply)

| | | | | | |
|--------------------|--------------------|-------------------|----------------------------|-------------------|--------------|
| Present Home is a: | House | Apartment | Mobile Home | Condo | Other: _____ |
| Present Home Has: | Forced Air Heat | Wood Stove | Wall (Baseboard) Heater | Air Conditioning | |
| Are There: | Damp Areas in Home | Mold in the House | Moisture under or in House | Attic or Basement | |

Bedroom Products Used: (Circle all that Apply) Mattress Waterbed Bunk Bed Other: _____

| | | | | | | |
|----------------|-------------------|-------|-------|---------------------------|----------|----------------------|
| Feather Pillow | Feather Comforter | Quilt | Futon | Wool or Electric Blankets | Carpeted | Window open at Night |
|----------------|-------------------|-------|-------|---------------------------|----------|----------------------|

Pet History: Cats: # _____ Are they ever indoors? Y N Do they sleep in Bedroom? Y N

Dogs: # _____ Are they ever indoors? Y N Do they sleep in Bedroom? Y N

Other Pets or Animals: _____ Do you have exposure to barns or ranch animals? Y N

Smoking History: Did you ever smoke? Y N For how long? _____ Packs/Day? _____ Did you Quit? Y N When? _____

Does anyone smoke inside your home currently? Y N Who? _____

◆Occupation: _____ School: _____ Hobbies: _____

◆Medication Allergies or Intolerance: _____ Are you Aspirin Sensitive? Y N

◆Food Intolerance: Milk Eggs Wheat Corn Shellfish Fruits Nuts Others _____ None

◆Insects: (Have you had strong reactions to) Bees Mosquitoes Others _____ No Reactions

◆Skin Contactants: (Strong reactions to) Poison Oak Metal Jewelry Others _____ No Reactions