**Allergy & Asthma Center of Southern Oregon, PC**
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# New Patient Questionnaire

Today's Date:____________________________ Home Phone:____________________________Cell Phone:______________________

Name:__________________________________________DOB:__________________________Age:____________M F

Occupation:______________________________ School:_________________________________Hobbies:_____________________________

Personal Information:_____________________________________________________________________________________________

OK to upload medications from your pharmacy: Y N Pharmacy:___________________________________________________

✦**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
✦**Most bothersome months**: (Circle all that Apply) **Jan Feb March April May June July Aug Sept Oct Nov Dec**

✦**Past Medical History**: (Circle 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:________________________________________________________

✦**Food Intolerance:** None Milk Eggs Wheat Corn Shellfish Fruits Nuts Others___________________________
✦**Insects:** (Have you had strong reactions to) No Reactions Bees Mosquitoes Others___________________________
✦**Skin Contactants:** (Strong reactions to) No Reactions Poison Oak Metal Jewelry Others___________________________
✦**Past Surgical History:**___________________________________________________________________________
✦**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:_________________________________

✦**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
Lived in present home: #yrs_______ Age of home:________ Location:__________________ Year Moved to Oregon_____________
In what geographic area have you spent most of your life? _______________________________________________________

✦**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
Do you use dust covers: Pillow Y N Mattress Y N

✦**Pet History:** Dogs: #________ Are they ever indoors? Y N Do they sleep in Bedroom? Y N
Cats: #________ 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?________________________________________

✦Are you on allergy shots: Y N Year started:________ Maintenance Building Inhalants Venoms
✦Do you take a Beta Blocker: Y N
✦Alcohol Use: Y N Exercise: Y N Drug Use: Y N
✦**Medication Allergies or Intolerance:**_______________________________________________ **Are you Aspirin Sensitive?** Y N
✦**Signature:**_________________________________________________ ✦**Date:**____________________