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: _____ Birth History: Full term? Y N Vaccines up to date: Y N

OK to upload medications from your pharmacy? Y N Pharmacy: _____

✦**Current Medical Symptoms**: (Circle 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 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

✦**Pets:** 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 at 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 Do you use marijuana? Y N

✦Are you Pregnant? Y N

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

✦**Signature:**_____ ✦**Date:**