CENTRAL TEXAS ALLERGY & ASTHMA

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NEW PATIENT QUESTIONNAIRE (Please fill out completely)

Name: _____ DOB: _____ Sex: M F Age_____ Date:_____

Years in Central Texas: _____ How did you find out about this practice? _____

Referring Physician: _____ Ph.: _____ Fax:_____

Private Physician: _____ Ph.#:_____ Fax:_____

Preferred Pharmacy: _____ Ph#:_____

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT: (Include duration of symptoms)

_____

_____

_____

NASAL SYMPTOMS: Age when symptoms began or first noticed: _____

Congestion:	☐ Almost daily	☐ Seasonally	☐ Rarely	☐ Intermittently
Post Nasal Drainage:	☐ Almost daily	☐ Seasonally	☐ Rarely	☐ Intermittently
Throat clearing:	☐ Almost daily	☐ Seasonally	☐ Rarely	☐ Intermittently
Runny Nose:	☐ Almost daily	☐ Seasonally	☐ Rarely	☐ Intermittently
Sneezing:	☐ Almost daily	☐ Seasonally	☐ Rarely	☐ Intermittently
Itching:	☐ Almost daily	☐ Seasonally	☐ Rarely	☐ Intermittently

Loss of Smell	☐ Yes	☐ No
Loss of taste	☐ Yes	☐ No
Bleeding	☐ Yes	☐ No
Snoring	☐ Yes	☐ No
Sleep apnea	☐ Yes	☐ No

ARE YOUR NASAL SYMPTOMS WORSE: Time of the year symptoms are the worst?

(*Check appropriate boxes*)

- ☐ Around strong odors
- ☐ With spicy foods
- ☐ Around dust
- ☐ In cold weather
- ☐ No seasonal change
- ☐ In high humidity
- ☐ With weather changes
- ☐ Air conditioning/drafts/wind
- ☐ Around smoke
- ☐ Feb – May
- ☐ June – Aug
- ☐ Sept – Nov
- ☐ Dec – Feb

ALLERGY HISTORY:

List dates and location of previous allergy tests: _____

Results: _____

List dates of previous allergy shots: Started: _____ Stopped: _____ ☐ Still getting

Did the shots help your allergies? ☐ Yes ☐ No ☐ Not Sure

Medicines taking for your allergies now: _____

Currently using Afrin/decongestant nasal sprays? ☐ Yes ☐ No If yes how often/how long? _____

Previously used medications for allergies: _____

EYES: ☐ Itching ☐ Burning ☐ Watery ☐ Redness ☐ Swelling ☐ Glaucoma ☐ Cataracts
Diagnosed with dry eyes? ☐ Yes ☐ No Do you wear contacts? ☐ Yes ☐ No
Do you use eye drops? ☐ Yes ☐ No If yes, which eye drops? _____

SINUS SYMPTOMS: (currently) ☐ Discolored drainage
☐ Pressure in cheeks ☐ Pain in cheeks ☐ Pressure around eyes for _____ days or weeks
Frequent sinus infections requiring antibiotics? ☐ Yes ☐ No If yes, how often? _____ per year
Have you had a sinus CT or X-ray? ☐ Yes ☐ No Date: _____ Results: _____
What was the last antibiotic you took? _____ When? _____
Have you had surgery on your nose or sinuses? ☐ Yes ☐ No _____
History of sinus polyps? ☐ Yes ☐ No If yes, was surgery done/ when? _____

HEADACHES:
Sinus Frequency: _____ times per: week month year
Migraines Frequency: _____ times per: week month year
Stress Frequency: _____ times per: week month year
Headaches associated with? ☐ Nausea ☐ Vomiting Triggers: _____
Medicines for headaches or migraines: _____ Do they help? ☐ Yes ☐ No

EARS: ☐ Pain ☐ Itching ☐ Ringing ☐ Loss of Hearing ☐ Dizziness
Frequent infections requiring antibiotics? ☐ Yes ☐ No If yes, how often? _____ per/year
Have you had tonsil/adenoids removed? ☐ Yes ☐ No If yes, when? _____
Have you had PE tubes in your ears? ☐ Yes ☐ No If yes, when? _____
Have you seen a ENT? ☐ Yes ☐ No If yes who? _____

CHEST SYMPTOMS: Asthma / COPD Diagnosed? ☐ Yes ☐ No ☐ Both If yes, age diagnosed: _____
Cough: ☐ Mild ☐ Moderate ☐ Severe **and** ☐ Daily ☐ Weekly ☐ Monthly ☐ Seasonally ☐ Intermittently
Wheeze: ☐ Mild ☐ Moderate ☐ Severe **and** ☐ Daily ☐ Weekly ☐ Monthly ☐ Seasonally ☐ Intermittently
Tightness: ☐ Mild ☐ Moderate ☐ Severe **and** ☐ Daily ☐ Weekly ☐ Monthly ☐ Seasonally ☐ Intermittently
Short of Breath ☐ Mild ☐ Moderate ☐ Severe **and** ☐ Daily ☐ Weekly ☐ Monthly ☐ Seasonally ☐ Intermittently
Current asthma medications: _____
Previous asthma medications: _____
Have you ever taken Montelukast/Singulair? ☐ Yes ☐ No
Have you received oral corticosteriods/steroid injections ☐ Yes ☐ No If yes, when? _____
Have you ever seen a Pulmonologist? ☐ Yes ☐ No If yes, which one? _____
With exercise do you have? ☐ Cough ☐ Wheeze ☐ Chest Tightness ☐ Shortness of Breath
Triggers: ☐ Cold ☐ Bronchitis ☐ Allergy ☐ Exercise ☐ Laughter ☐ Weather ☐ Smoke ☐ Dust ☐ Animals
Cough triggered by exercise ? ☐ Yes ☐ No Cough triggered by laughter ? ☐ Yes ☐ No
Night Awakenings (due to breathing difficulty): _____ times/week _____ times/month
Have you had a chest X-ray/CT scan of the chest? ☐ Yes ☐ No Date: _____ Results: _____
Do you have a nebulizer (Breathing Machine)? ☐ Yes ☐ No How often do you use it? _____
Medications you use in nebulizer? _____

Have you been to an Urgent Care/Texas Medical Clinic/ Emergency room for asthma? ☐ Yes ☐ No Dates:_____

Have you ever had pneumonia? ☐ Yes ☐ No Dates: _____

Have you ever been hospitalized for your asthma? ☐ Yes ☐ No Dates: _____

Have you ever had RSV? ☐ Yes ☐ No Dates: _____

Have you ever been hospitalized for? ☐ Chest pain ☐ Palpitations ☐ Increased heart rate

Are you / Have you been a smoker? ☐ Yes ☐ No # of years: _____ # packs/day: _____

Would you like to quit? ☐ Yes ☐ No or Quit _____ years ago

Any smokers in your family/second hand smoke exposure? ☐ Yes ☐ No

Do you use chewing tobacco? ☐ Yes ☐ No Amount: _____

SKIN:

Do you have eczema? ☐ Yes ☐ No

Do you have hives? ☐ Yes ☐ No

Triggers: _____

Current skin medication: _____

Previous skin medication: _____

Have you seen a Dermatologist? ☐ Yes ☐ No If yes, which one? _____

DIET HISTORY:

Do you have an Epi-Pen? ☐ Yes ☐ No

Do you have a food allergy? ☐ Yes ☐ No

If yes, which food? _____

Type of Reaction: _____

REFLUX HISTORY:

Do you have heartburn, acid reflux, GERD? ☐ Yes ☐ No If yes, medications: _____

How many caffeinated beverages (coffee, soda, tea, etc...) do you drink per day? _____

How many alcoholic beverages do you drink per day? _____

Do you eat late night meals or fast food often? _____

VACCINATIONS:

Are your vaccinations up to date? ☐ Yes ☐ No

Have you had the influenza vaccine? ☐ Yes ☐ No When? _____

Have you had the pneumonia vaccine? ☐ Yes ☐ No When? _____

Have you had the COVID vaccine? ☐ Yes ☐ No When? _____

FAMILY HISTORY: ☐ Unknown

	Father	Mother	Brother	Sister	Children	Grandparent
Asthma	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐

Other _____

List all medications you are taking and why you take them **(do not include allergy or asthma medications.)**

MEDICATION	DOSE	REASON FOR TAKING MEDICATION MEDICATION DIRECTIONS	APPROX. START DATE

SURGICAL HISTORY:

Have you had any surgery? ☐ Yes ☐ No

Type of surgery and date: _____

ENVIRONMENT/SOCIAL:

What is your present occupation? _____ Past occupation: _____

☐ Married ☐ Single ☐ Divorced ☐ Widow ☐ Other _____

Any children? ☐ Yes ☐ No How many? _____ Where were you born and raised? _____

Is your home in the ☐ Country ☐ Residential ☐ Rural / Residential ☐ Central AC

☐ Carpet in bedrooms ☐ Ceiling fan in bedroom ☐ Dust mite covers on pillows and mattress

Are you exposed to dust / chemicals / fumes at work? ☐ Yes ☐ No

Number of pets: Dogs _____ Cats _____ Birds _____ Other _____

Do pets come indoors? ☐ Yes ☐ No Do pets come in your bedroom? ☐ Yes ☐ No

Are your symptoms worse around the animals? Cat? ☐ Yes ☐ No Dog? ☐ Yes ☐ No Other ☐ Yes ☐ No

MEDICAL HISTORY:

Are you allergic to any medication(s) or latex? ☐ Yes ☐ No

If yes, which medications: _____

Type of reaction: _____

If yes to penicillin, would you be interested in skin testing to verify this allergy? ☐ Yes ☐ No

Reaction to an insect sting? ☐ Yes ☐ No Type of insect if known: _____

Type of reaction and when: _____