HennepinHealthcare

Allergy Clinic

Name: _____
Date of Birth: _____
Today's Date: _____

New Patient Questionnaire

Primary Care Provider's Name: _____
Primary Clinic: _____

Was a consultation recommended? ☐ Yes ☐ No
Referring provider's name (if different): _____

Please answer the following questions to facilitate the diagnosis of your specific condition.

Physician's notes

The reason(s) for your appointment:

☐ Yes ☐ No Nasal or Sinus symptoms
☐ Yes ☐ No Eye symptoms
☐ Yes ☐ No Asthma
☐ Yes ☐ No Cough
☐ Yes ☐ No Eczema
☐ Yes ☐ No Hives *(see page 4)*
☐ Yes ☐ No Food Reactions *(see page 4)*
☐ Yes ☐ No Insect Stings *(see page* 5)
Other _____

If you have nasal or sinus symptoms, do you have:

☐ Yes ☐ No Nasal congestion
☐ Yes ☐ No Runny nose
☐ Yes ☐ No Itching
☐ Yes ☐ No Sneezing
☐ Yes ☐ No Stuffiness
☐ Yes ☐ No Drainage down throat
☐ Yes ☐ No Yellow/green drainage
☐ Yes ☐ No Bleeding
☐ Yes ☐ No Poor sense of smell
☐ Yes ☐ No History of nasal polyps
☐ Yes ☐ No History of sinus surgery Date: _____
☐ Yes ☐ No Sinus headaches
☐ Yes ☐ No History of sinus infections
How many in the past year? _____
☐ Yes ☐ No Have you used nasal sprays?
~~If yes, names:~~ _____
_____
☐ Yes ☐ No Have you used pills for symptoms?
~~If yes, names:~~ _____
_____

If you have eye symptoms, do you have:

☐ Yes ☐ No Itching
☐ Yes ☐ No Watering
☐ Yes ☐ No Redness
☐ Yes ☐ No Burning
☐ Yes ☐ No Discharge/Crusting
☐ Yes ☐ No Have you used eye drops?
~~If yes, names:~~ _____
_____

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Physician's notes

When do Nasal/Sinus/Eye Symptoms occur:

☐ Spring
☐ Summer
☐ Fall
☐ Winter
☐ All the time

☐ Morning
☐ Evening
☐ During sleep
☐ At work/school
☐ Outdoors
☐ Indoors

Nasal/Sinus/Eye Symptoms are made worse by:

☐ Cats
☐ Dogs
☐ Dust
☐ Exercise
☐ Colds/infections
☐ Cigarette smoke
☐ Humidity
☐ Cold

☐ Mowing grass
☐ Raking leaves
☐ Heat
☐ Temperature changes
☐ Perfumes/scents
☐ Foods: _____
☐ Drugs: _____
☐ Other: _____

If you have Asthma or Cough Symptoms, do you have:

☐ Yes	☐ No	Wheeze
☐ Yes	☐ No	Shortness of breath
☐ Yes	☐ No	Chest tightness
☐ Yes	☐ No	Cough during sleep
☐ Yes	☐ No	Productive cough with mucus
☐ Yes	☐ No	Heartburn
☐ Yes	☐ No	Diagnosis of asthma? Age: _____
☐ Yes	☐ No	Symptoms as a child. If yes, age started: _____
☐ Yes	☐ No	Hospitalizations for asthma? If yes, number: _____
☐ Yes	☐ No	ER visits for asthma. If yes, number: _____
☐ Yes	☐ No	Did symptoms cause you to miss days of school or work in past year? If yes, number: _____
☐ Yes	☐ No	Have you used inhalers for symptoms? If yes, names: _____

Asthma/Cough symptoms occur:

☐ Spring
☐ Summer
☐ Fall
☐ Winter
☐ All year

☐ Morning
☐ Afternoon
☐ Evening
☐ Nighttime
☐ At home
☐ At work/school

Asthma/cough symptoms are made worse by:

☐ Animals
☐ Dust
☐ Smoke
☐ Foods
☐ Infections

☐ Colds
☐ Humid air
☐ Exercise
☐ Cold air
☐ Drugs: _____

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Home Environment

☐ House
☐ Apartment/condo
☐ Mobile home
☐ **Cats** How many? _ _
☐ **Dogs** How many? --
☐ Birds
☐ Other pets_____
☐ Feather pillow
☐ Down comforter
☐ Bedroom carpet
☐ Room air cleaner

☐ City
☐ Country/Woods/Lake
☐ Suburb
☐ Cigarette smoke
☐ Forced air heat
☐ Wood burning stove/fireplace
☐ Air conditioning
☐ Damp basement
☐ Mold growth
☐ Whole house air cleaner

Physician's notes

Social history

Occupation: _____
If child, primary residence is:
☐ One home ☐ Split between homes
Leisure activities:

Review of Systems *Circle all that apply*

General	Weight gain	Weight loss	Changes in sleep
Ears	Fullness	Decreased hearing	Dizziness
Nose	Snoring	Change in sense of smell	Drainage
Throat	Hoarseness	Soreness	Difficulty Swallowing
Respiratory	Shortness of breath	Wheeze	Sputum
Cardiovascular	Chest pain	Swelling of ankles	Palpitations
Gastrointestinal	Nausea	Heartburn	Reflux
Musculoskeletal	Joint pain	Joint stiffness	Joint swelling
Neurologic	Seizures	Fainting	Weakness
Psychiatric	Changes in mood	Anxiety	
Endocrine	Cold intolerance	Heat intolerance	Tremor
Hematologic	Bleeding	Bruising	
Skin	Rash	Scaling	Nail changes

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New Patient Questionnaire

Hives

If you are concerned about hives, please answer the questions below:

Do the following symptoms happen at the same time?

☐ Yes ☐ No Wheeze
☐ Yes ☐ No Trouble swallowing
☐ Yes ☐ No Throat tightness
☐ Yes ☐ No Abdominal cramping
☐ Yes ☐ No Swelling of lips/eyelids/hands/feet

☐ Yes ☐ No Are you under increased stress?
☐ Yes ☐ No Have you recently taken new medications or supplements?
☐ Yes ☐ No Has the dose of your medications recently changed?
☐ Yes ☐ No Have you had a recent infection?
☐ Yes ☐ No Do you have contact with latex?
☐ Yes ☐ No Do you have a history of hepatitis?
☐ Yes ☐ No Do you or your family history of low or high thyroid?
☐ Yes ☐ No Do you or your family have a history of lupus or rheumatoid arthritis?
☐ Yes ☐ No Do any family members have hives or swelling episodes?

Physician's notes

_____

Do any of the following cause hives or swelling?

☐ Heat ☐ Cold
☐ Exercise ☐ Stress
☐ Pressure ☐ Foods
☐ Medicines ☐ Aspirin/Ibuprofen
☐ Foods ☐ Menses

Food Allergy

If you are concerned about a food allergy, please answer the questions below:

What symptoms occur after eating a specific food?

☐ Hives ☐ Abdominal pain
☐ Swollen throat ☐ Vomiting
☐ Itchy throat ☐ Diarrhea
☐ Nasal congestion ☐ Asthma
☐ Eczema ☐ Other

How much of the food is eaten for the reaction to occur?_____
How soon after eating do the symptoms occur?_____

☐ Yes ☐ No Do you know what foods cause reaction?
If yes, specify: _____

☐ Yes ☐ No Has the reaction required an ER visit or hospitalization?
If yes, when: _____

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Insect Stings

If you are concerned about insect stings, please answer the questions below:

Physician's notes

What symptoms occur after you are stung by an insect?

☐ Hives
☐ Swollen throat
☐ Itchy throat
☐ Nasal congestion
☐ Swelling
☐ Abdominal pain
☐ Vomiting
☐ Diarrhea
Asthma
☐ Loss of consciousness

How many insects stung you right before the reaction occurred? _____
How soon after you were stung did the symptoms occur? _____

☐ Yes ☐ No Do you know ~~what insect (wasp, yellow jacket, hornet, honeybee) causes a reaction?~~
If yes, specify: _____

☐ Yes ☐ No Has the reaction required an ER visit or hospitalization?

If yes, when: _____

Is there anything else you would like the doctor to know?