

ALLERGY HEALTH & ENVIRONMENT QUESTIONNAIRE

Patient name _____ DOB _____ Age _____ Visit Date _____

Primary Care Provider _____ How did you hear about us? _____

CC: What's the main reason(s) for your office visit with us? _____

HPI/ROS: Check "√" if you are currently bothered by the following symptoms:

PROVIDER'S

COMMENTS:

- | | | |
|--|--|--|
| <input type="checkbox"/> Sinus pain/pressure | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Throat clearing | <input type="checkbox"/> Rash |
| <input type="checkbox"/> Itchy/watery eyes | <input type="checkbox"/> Loss of taste/smell | <input type="checkbox"/> Hives/Allergic swelling |
| <input type="checkbox"/> Red eyes | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Dry skin |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Cough | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Itchy nose/throat | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weight change |

ROS: Check "√" if you currently or routinely experience the following symptoms:

- | | | |
|---------------------------------------|--|---|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Swollen lymph nodes | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Easy bleeding | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Palpitations | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Joint pain |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Vision changes | <input type="checkbox"/> Joint swelling |
| | | <input type="checkbox"/> Muscle pain/cramps |

Past Medical/Surgical History: Check "√" if you have a history of:

- | | | |
|--|---|--|
| <input type="checkbox"/> Asthma | Diagnosed when? _____ | # of Hospitalizations for Asthma _____ |
| <input type="checkbox"/> COPD | <input type="checkbox"/> Eczema | |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Nasal polyps | <input type="checkbox"/> Sinus surgery |
| <input type="checkbox"/> Frequent bronchitis | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Tubes in ears |
| <input type="checkbox"/> Frequent sinus infections | <input type="checkbox"/> Severe allergic reaction | <input type="checkbox"/> Tonsillectomy |
| <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Gastric reflux disease | <input type="checkbox"/> Adenoidectomy |

Other medical problems: _____

Family History: Check "√" if anyone in your family has one of these conditions.

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Immunodeficiency |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Chronic bronchitis | <input type="checkbox"/> Cystic Fibrosis |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Emphysema | |

Other (list:) _____

Social/Environmental History: Check "√" if any of the below apply to you.

- | | |
|---|--|
| <input type="checkbox"/> Current smoker | <input type="checkbox"/> Works/school allergen/irritant exposure |
| <input type="checkbox"/> Previous smoker | <input type="checkbox"/> Daycare exposure |
| <input type="checkbox"/> Second-hand smoke exposure | <input type="checkbox"/> Damp/wet/flooded home |
| <input type="checkbox"/> Animal exposure | <input type="checkbox"/> Farm/rural dwelling |

Other (list:) _____