Welcome to New England Allergy, Asthma, Immunology & Primary Care, P.C.!
Please complete the following questionnaire prior to your visit.
You may submit electronically or print at home and bring with you to the office.

Name: _____ Date: _____
Date of Birth: _____

1. What is your principal reason for consulting us? _____

_____

2. Circle any of the following that you have had:

Sneezing	Runny nose	Stuffy nose	Sinus congestion
Phlegm	Headaches	Watery eyes	Post-nasal drip
Cough	Wheezing	Tight chest	Shortness of breath
Eczema	Skin rash	Hives	Swelling
Hay fever	Poison ivy	Hoarseness	Bee sting reaction
Asthma	Bronchitis	Ear blockage	Ear infections
Sinusitis	Nasal polyps	Frequent colds	
Pneumonia	Loss of smell	Skin infections	

3. Underline the months that you have symptoms. Circle the worst ones.
Jan Feb Apr May Jun Jul Aug Sept Oct Nov Dec All the same

4. On average, how often do you have symptoms?
Daily Weekly Monthly 2-3 Times per Month All the time

5. How long ago, or at what age, did you first have symptoms?

6. Circle any of the following which seem to cause your symptoms:

Cat	Barns	Air conditioning
Dog	Musty areas	Cold air
Horse	Basements	Exercise
Birds	Tobacco Smoke	Weather changes
Other animals	Perfume	Warmth
Mowing grass	Other fumes	Humid weather
Raking leaves	Alcohol	Work environment
Dusting	Viruses or colds	Emotional stress
Foods: _____	_____	_____

7. Circle what describes your home environment:

Dry	Urban	Pillows:	feather	foam	polyester				
Damp	Suburban	Heat:	air	water	steam	oil	gas	wood	
Musty	Rural								
Dusty									

8. Do you have pets? None Dog Cat Bird Other: _____

9. What kind of work do you do? Are your symptoms different at work than at home?

10. Have you ever had allergy skin tests? Yes No

If so, when and by whom? _____

Do you know of any positive results from that time? _____

11. Were you ever treated with allergy injections? Yes No

12. What, if anything, usually relieves your symptoms? _____

13. What medications have you taken for these symptoms? _____

What are you taking now?_____

Do they help? Yes No Somewhat

Have you ever used nose sprays? Yes No

Have you ever taken steroids (Prednisone, Medrol, etc.)? Yes No

If so, when was the last time? _____

14. Please list all the medications that you are taking presently (including vitamins, birth control pills, etc.)

_____

_____

_____

15. Have you ever lived in or visited other areas where your symptoms were better or worse? Yes No

If so, where? _____

16. Are you allergic or sensitive to any medications?
If so, please name the medications and what kind of reactions _____

_____

17. Were your childhood immunizations completed for diphtheria, tetanus, whooping cough (pertussis), measles, mumps, rubella, and polio? Yes No

18. Have you ever had any reactions to any vaccinations or immunizations? Yes No

If so, which one(s) and what was the reaction? _____

19. Have you ever had the flu shot? Yes No

Have you ever had the pneumonia vaccine (Pneumovax or Prevnar)? Yes No

20. When was your last TB test? _____ Please circle: Positive Negative

21. Circle any of the following conditions that you have had:

Scarlet Fever	Diabetes	Cancer
Rheumatic Fever	High blood pressure	Tuberculosis
Hepatitis	Heart attack	Mono (“mononucleosis”)
Heart murmur	Tonsillectomy	Stroke
Nasal or cranial surgery	Arthritis	
Heartburn	Ulcers	

Please list other surgeries or medical conditions not listed above: _____

_____

_____

_____

22. Have you ever been a smoker? Yes No When did you quit?_____

How many packs per day? _____ For how many years? _____

23. Does anyone in your immediate family suffer from allergies?

Hay Fever Asthma Eczema Hives Swelling of the face

24. How have you been recently? _____

_____

_____

_____

Please answer the following only if you have had asthma or wheezing.

25. How often do you wheeze? All the time Several times per--- day week month year

26. How long does it usually last? Minutes Hours Days

27. When was your last bout of wheezing? _____

28. Have you been treated in hospital emergency rooms for wheezing/asthma? Yes No

If so, how many times in the past year? _____

29. Circle any of the following which seem to cause or aggravate your wheezing:

Infections	Animals	Work area
Colds	Smoke	Emotional stress
Cold air	Fumes	Weather changes
Exertion/exercise	Seasons: Summer Fall Winter Spring	
Foods:_____	_____	_____
Medications: _____	_____	_____

Other: _____

_____

30. Have you had any reactions to asthma medications? Yes No

If so, what happened? _____

31. Have you been treated with any of the following (please circle):

Theophyllines (any brand)

Inhalers (Primatene, Isuprel, Bronkometer, Alupent, Metaprel, Ventolin, Proventil)

Beclomethasone (Vanceril, Beclovent)

Cromolyn (Intal spinhaler)

32. When was your last chest x-ray?

33. Have you ever had pulmonary function tests (breathing tests) performed at a hospital or other office?

34. Have you ever had tuberculosis (TB)? Yes No

Urticaria History Questionnaire: Please answer only if you have urticaria, hives or swelling

1. Do you have "hives" (itchy bumps or welts), swelling of areas of skin, or both? Underline which you have; circle which occurs the most. Hives Swelling Both

2. How often does this occur? Every Day Several times per-- Week Month Year

3. How long has this been going on? _____

4. Has this ever happened before? _____

5. About how long will an average individual hive or swelling episode last? Minutes Hours A Day Multiple Days

6. Do they: itch burn hurt prickle

7. Where do they occur?

Hands	Face	Chest	Arms
Feet	Lips	Abdomen	Legs
Scalp	Ears	Back	Throat

8. Do you have any associated symptoms? Please circle from the following:

Flushing	Difficulty breathing	Wheezing
Stomach pain	Difficulty swallowing	Headache
Diarrhea	Joint pain	Joint swelling

9. Have you noted or suspected any obvious causes? Yes No Maybe

Please describe: _____

10. Circle any of the following which seem to cause or worsen your symptoms:

Heat	Sunlight	Menstrual periods	Workplace
Cold	Exertion/exercise	Wool	Aspirin
Rubbing	Sweating	Metals	
Vibration	Emotional stress	Alcohol	
Pressure	Cosmetics	Animals	

Foods: _____

Medications: _____

11. Were any of the following new or different about the time or shortly before this problem started? Please circle.

Pets	Clothing	House	Laundry Detergent	Bath soap
Job	Home furnishings	Insulation	Fabric softener	Diet

Please describe: _____

_____

Asthma Screening Questions

1) Are you sleeping through the night without coughing, wheezing, or shortness of breath?

_____

2) How often are you having to get up and use your bronchodilator at night?

_____

3) How many times a week do you wake up coughing or wheezing?

_____

4) Does your oral asthma medication seem to keep you awake at night?

_____

5) How long does your bronchodilator inhaler normally last?

_____

6) Does your asthma prevent you from leaving your home, or engaging in certain activities?

_____

7) Has your asthma kept you from attending work or school?

_____

8) Are your activities of daily living or ability to exercise affected by your asthma? (Ex: climbing stairs, housework, hobbies, gardening)

_____

9) How do you feel your asthma symptoms are controlled overall? (Fair, good, very good, poor)

_____