Allergy, Asthma & Immunology Center
OF SOUTHWEST LOUISIANA

Dr. Bina Joseph

Patient (Parent) Questionnaire

Patient's Name: _____ DOB: _____ Date: _____

Referred By: _____ Primary Care Physician: _____

Describe each problem that has led you to seek this allergy evaluation:

1. _____
2. _____
3. _____
4. _____

Drug Allergies: Please list all drug allergies and describe your reaction to each one of them: hives/rashes/stomach problems/life threatening events that required ER visit or hospitalization.

Name of Drug	Type of Reaction

Current Medications:

_____
_____
_____
_____
_____
_____

Insect Allergy: Please list the reaction and describe your reaction to each one of them: hives/rashes/stomach problems/life threatening events that required ER visit or hospitalization.

Name of Stinging Insect	Type of Reaction

Food Reactions/Intolerances

Do you have any problems with any foods? Yes _____ No _____
If so, what foods cause your problems?

_____
What kind of problems do you experience? List all that apply: Hives/Rashes/Stomach upset/Nausea/Vomiting/Bloating/Diarrhea/Life threatening event that required ER visit or hospitalization:

Name of Food	Type of Reaction to Food

Were you/your child ever prescribed an Epi-pen? Yes _____ No _____
Are you on any special diet? Yes _____ No _____
If yes what kind of diet? _____

Medical History

Medical Diagnosis	Hospitalizations
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____
6. _____	6. _____

IF YOU HAVE HAD ANY ALLERGY TESTS OR LABS DONE PLEASE BRING RESULTS WITH YOU TO YOUR APPOINTMENT.

Recent Labs? _____Yes _____No

- If yes what labs were done? When and where were they done? _____

Recent X-rays? Chest or CT of Sinus or Chest _____Yes _____No

- If yes what was done? When and where were they done? _____

Ever been allergy skin tested/allergy blood tested?

- If yes when and where were they done? _____
- History of allergy shots/allergy drops? _____Yes _____ No
    - If so how long ago were they completed? _____

Have you ever had a Pneumococcal vaccine? Yes _____ No _____
When was your last Flu shot? _____
Have you ever had an immune workup done? Yes _____ No _____

Factors affecting you or your child's symptoms:

When are your symptoms worse?
_____ Spring _____ Summer _____ Fall _____ Winter

Indicate the things below that make your symptoms worse.

Exercise	Burning of Sugar Cane	Strong Odors	Smoke
Dust	Change in Humidity	Morning	Pet Dander
Mold/Mildew	Change in Temperature	Afternoon	Feathers
Pollen	Alcohol	Evening	Colds/Respiratory Infections
Hay	Outside	Medications	Fatigue
Perfume/Cologne	Inside	Grass	Stress

Environmental History:

What kind of house do you live in?

_____ House

_____ Apartment

_____ Mobile Home

Do you have carpeting? Yes _____ No _____

Do you have any pets?

_____Cats

_____Dogs

_____Horses

_____Other: List _____

What is the approximate age of your home? _____

Is your mattress encased in a dust proof covering? Yes _____ No _____

Is your pillow encased in a dust proof covering? Yes _____ No _____

Do you have a moisture problem in your home? Yes _____ No _____

What kind of air conditioning do you have?

_____Central Air

_____Window Units

Is there anything unusual or remarkable about your home?

Tobacco Smoke Exposure:

Are there smokers in the home? Yes _____ No _____

Do you smoke? Yes _____ No _____

If yes: Cigarette _____ Pipe _____

Chew _____ Marijuana _____

If yes, how much do you smoke in a day? _____

How long have you smoked? _____

CHECK OFF ALL THAT APPLY:

Family History	Allergies	Food Allergies	Hives or Swelling of Skin	Asthma	Immune Deficiency
Mother					
Father					
Brothers					
Sisters					

Social History:

Where do you work or go to school? _____
What is your work environment? _____
_____
Do you live near pollutants or industry? Yes _____ No _____

Symptom History: Check any of the following symptoms that you had or have now:

NOSE/THROAT/HEAD

_____ Frequent colds
_____ Frequent congestion
_____ Postnasal drainage
_____ Runny nose
_____ Frequent sneezing
_____ Frequent rubbing/itching of nose or throat
_____ Nosebleeds
_____ Sinus infections
  _____Number of antibiotics prescribed in the last year: _____
  _____Number of steroids prescribed in the last year: _____
_____ Headaches
  _____ Nausea and Vomiting with Headaches
  _____ Frequency
  _____ Triggers _____
  _____ Sensitivity to light
_____ Nasal polyps
_____ Snoring
_____ Mouth breathing
_____ Bad breath
_____ Hoarseness
_____ Frequent Tonsillitis
_____ Enlargement of the Tonsils

EYES

_____ Redness
_____ Itching or rubbing of eyes
_____ Watering
_____ Swelling
_____ Dark circles
_____ Dry eyes

EARS

_____ Frequent infections _____ Number of infections in past year _____
_____ Fluid
_____ Popping of ears
_____ Itching of ears
_____ Ear tubes _____How many sets of tubes and when were they placed? _____
_____ Hearing loss
_____ Speech problems
_____ Dizziness(Vertigo)

NECK

_____ Thyroid enlargement

CHEST

_____ Frequent cough

_____ AM _____ PM _____ All Day

_____ Shortness of breath

_____ Wheezing

_____ Exercise intolerance

_____ Productive Mucous or Sputum

_____ Pneumonia

_____ How many times diagnosed with this? _____

_____ Bronchitis

_____ Frequent croup _

_____ Symptoms cause wakening from sleep

_____ How often? _____

_____ History of asthma

GASTROINTESTINAL

_____ Frequent vomiting

_____ Frequent Diarrhea

_____ Abdominal Pain

_____ Heart burn

_____ Stomach Ulcers

_____ History of reflux

_____ Excessive belching

SKIN

_____Eczema _

_____Hives (welts)

_____Itching of skin

CARDIAC

_____ High Blood Pressure

_____ Name of Blood Pressure Medication _____

_____ Any other cardiac problem? _____

URTICARIA/HIVES

Skip this section if this does not pertain to you.

- How long have you had hives? _____
- Is this the first time you have ever had hives? Yes _____ No _____
    - If No indicate the last time you had hives: _____
- How often do you break out in hives? _____
- Do they ever go away? Yes _____ No _____
- Where do you break out in hives? Arms/Legs/Abdomen/Feet/Hands/Face/All over
- How long do the hives last? < 12 hours, < 24 hours, or several days?
- Do you know anything that triggers the hives? Yes _____ No _____
    - If yes indicate what triggers the hives: _____
      _____
- Do the hives itch? Yes _____ No _____
- Are the hives painful? Yes _____ No _____
- Do the hives leave bruises? Yes _____ No _____
- Have you had any associated swelling of lips, tongue, hands, feet, nausea, vomiting or stomach pain along with the hives? If yes circle all that apply.
- What medications have you tried for the hives and do they help?

Name of Medication	**Helpful or Not Helpful**

- Have you ever gone to the emergency room for treatment? Yes _____ No _____
    - If yes how many times? _____
    - When was your last ER visit? _____
- Do you have any of these symptoms below? (check all that apply)
    - Cold intolerance
    - Constipation
    - Weight gain
    - Weight loss
    - Fatigue? If so how long? _____
    - Joint/Muscle pain
    - Hair loss
    - Mouth ulcers
- Is there a family history of Lupus/Rheumatoid Arthritis/Sjorgren's
- Has any recent lab work been done since you have begun with the hives?
  Yes _____ No _____
  If yes when and where were they done? _____