NEW PATIENT-- QUESTIONNAIRE

Allergy & Asthma Associates of Maine

MUSMAND, MD; CHILMONCZYK, MD; CARDONA, MD, SIGLER, MD
www.allergyme.com

Please complete this questionnaire and print and bring it with you to your scheduled visit.

Name:____________________________
Date:____________
DOB: ____________**AGE:** ______ **SEX:** _____

Referring MD: ___________________________

Primary Care MD: _______________________

REASON FOR YOUR VISIT TO OUR OFFICE:

PLEASE LEAVE THIS AREA BLANK.

CHEST SYMPTOMS: (Check here ☐ if NONE)

WHEN DID SYMPTOMS BEGIN? ____
HAVE YOU/YOUR CHILD BEEN DIAGNOSED WITH ASTHMA?_________________

SYMPTOMS (CIRCLE): COUGH WHEEZE CHEST TIGHTNESS SHORTNESS OF BREATH
SYMPTOMS WITH (CIRCLE): NIGHT-TIME ANIMALS EXERCISE COLDS OTHER__________
ARE SYMPTOMS: DAILY? (times/day _____) or **WEEKLY?** (times/week_____)
NIGHT-TIME AWAKENING (times/month______)
HOW MANY DAYS OF MISSED SCHOOL OR WORK IN PAST YEAR?____________

WORSE IN: YEAR-ROUND? SPRING? SUMMER? FALL? WINTER?

HOW OFTEN IS ALBUTEROL OR XOPENEX USED? ______________________**x Week**
HOW OFTEN HAVE ORAL STEROIDS BEEN USED IN THE LAST YEAR? __________

EMERGENCY ROOM (ER) VISITS IN THE LAST YEAR?__________________________
HOSPITAL ADMISSIONS FOR ASTHMA?_______________________________________

EYES, EARS, NOSE, THROAT: (Check here ☐ if NONE)

WHEN DID SYMPTOMS BEGIN_____________________

SYMPTOMS (CIRCLE)? ITCHY RUNNY POST-NASAL DRIP STUFFY ITCHY/WATERY EYES LOSS OF SMELL

WORSE IN: YEAR-ROUND? SPRING? SUMMER? FALL? WINTER?
SYMPTOMS WORSENED BY: ANIMALS ODORS DUST OTHER?____________

TREATED FOR SINUSITIS? NUMBER OF TIMES IN THE PAST YEAR?_____________
POLYPS and/or SINUS SURGERY?____
NUMBER OF EAR INFECTIONS TREATED IN THE PAST YEAR? _________________
TUBES?____________**TONSILLECTOMY?**___________**ADENOIDECTOMY?**___________

FOOD SYMPTOMS: (Check here □ if NONE)

WHICH FOODS? MILK EGG WHEAT SOY PEANUTS TREE NUTS FISH/SHELLFISH OTHER____________________

DESCRIBE SYMPTOMS____________________

IF YES, TIME FROM INGESTION TO SYMPTOMS?
IMMEDIATE <10 Min <30 Min <2 Hrs >2Hrs 24 Hrs >24 Hrs

SKIN SYMPTOMS: (Check here □ if NONE)

SYMPTOMS: HIVES SWELLING ITCHING RASH

WHEN DID THEY START?____________________
DESCRIBE HIVES, SWELLING OR RASH____________________
IF HIVES, DO THEY LAST MORE THAN 24 HOURS OR LEAVE MARKS?____________________
WHAT MAKES WORSE?____________________
WHAT MEDICATIONS HAVE BEEN TRIED?____________________

PAST MEDICAL HISTORY? (List):

____
____
____

PRIOR SURGERIES/HOSPITALIZATIONS

____________________DATE: ______ ____________________DATE: ______
____________________DATE: ______ ____________________DATE: ______

BIRTH HISTORY (IF CHILD):
BIRTH WEIGHT: ________ **FULL TERM?** ______ **(IF NO, HOW MANY WEEKS EARLY?** __________)
OXYGEN REQUIRED AFTER BIRTH? ________ **BREATHING MACHINE AFTER BIRTH?** ___________

IMMUNIZATIONS: **UP TO DATE?** ______ **FLU SHOT?** ______ **PNEUMONIA SHOT?** _____
Chicken pox (varicella) vaccine OR had Chicken pox infection?_______

CURRENT MEDICATIONS: (including over the counter, herbal, etc):

____
____
____
____

DRUG ALLERGIES/ADVERSE REACTIONS: (NONE □)

DRUG ____________________ **REACTION** ____________________
DRUG ____________________ **REACTION** ____________________
DRUG ____________________ **REACTION** ____________________

FAMILY HISTORY: (circle all that apply)

MOTHER:	Asthma	Hay fever	Eczema	Food allergy	Hives	Frequent infections	Other_______
FATHER:	Asthma	Hay fever	Eczema	Food allergy	Hives	Frequent infections	Other_______
SISTER(S):	Asthma	Hay fever	Eczema	Food allergy	Hives	Frequent infections	Other _______
BROTHER(S):	Asthma	Hay fever	Eczema	Food allergy	Hives	Frequent infections	Other _______

OTHER CHRONIC CONDITIONS:

Cystic fibrosis __________________ COPD/Emphysema ____________ Autoimmune Disease______________
Other__________________________

SOCIAL HISTORY: (circle all that apply)

MARITAL (OR PARENTS') **STATUS**: **Single** **Married** **Divorced** **Widow**

SMOKER? Y / N PACKS/DAY _____

OCCUPATION?_______________________________

SCHOOL? Y / N (WHAT GRADE? ___________________)

HOBBIES? Y / N (IF YES, WHAT? ______________________)

DAY CARE? Y / N (DAYS A WEEEK_____)

ENVIRONMENT:

INDOOR/OUTDOOR PETS? CATS (#. ___)**DOGS** (#. ___)**BIRDS** (#. ___) OTHER ___________

AGE OF HOUSE _________ **YEARS AT RESIDENCE** ______ **TYPE OF HOUSE** __________

ANYONE SMOKE AT HOME? __________ **PACKS/DAY** _____

DO YOU HAVE: (Circle if positive)

BEDROOM CARPETTIING? STUFFED ANIMALS? DUST MITE COVERS?

HUMIDIFIER? DAMP BASEMENT? WATER DAMAGE/FLOODING?

FORCED AIR HEAT? WOOD HEAT? FIREPLACE? AIR CONDITIONING?

Other concerns you have about the home _______________________________________

OTHER CONDITIONS: (check here □ if all are negative; circle if present):

Fever Night sweats Weight loss Fatigue Swollen glands Anemia

Easy bruising Headaches Seizures Vision loss Hearing loss Hoarseness

Palpitations Chest pain Difficulty swollowing Vomiting High blood pressure

Heartburn Belly pain Choking on food/liquid Diarrhea Constipation

Bloody stools Joint pain/swelling Osteoporosis Anxious Depressed

Other____

Other Information that you want the doctor to know:

PLEASE LEAVE THIS AREA BLANK.

PHYSICAL EXAM (VITALS IN CHART)

	Normal	Abnormal	Comments (if abnormal)
General:	_______	_______	______________________________
SKIN:	_______	_______	______________________________
Lymphatics:	_______	_______	______________________________
Head:	_______	_______	______________________________
Eyes:	_______	_______	______________________________
ENT:	_______	_______	______________________________
Neck:	_______	_______	______________________________
LUNGS:	_______	_______	______________________________
CV:	_______	_______	______________________________
Abdomen:	_______	_______	______________________________
Musculosk:	_______	_______	______________________________
Extremities:	_______	_______	______________________________
Neuro/Psych:	_______	_______	______________________________

DATA (Skin Tests, PFTs, Outside Med Records, CXR, Chest CT, Sinus X-Ray, Sinus CT, Etc.)

ASSESSMENT:

PLAN: