MORRIS HOSPITAL
ALLERGY SPECIALISTS

Allergy New Patient History Form

What is the main reason you need to see an allergist today? Please explain in detail.

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_____

_____

_____

How long have you been having this problem?

- 1-2 months
- 3-6 months
- 7 – 12 months
- 2-4 years
- More than 5 year
- Since childhood

How often do you experience your most concerning symptoms or problems?

- Daily
- 2-3x a week
- 2-3x a month
- 2-3x every 3 months
- Occasionally
- Not as frequent

How long have you been experiencing your problem(s) for?

- Less than 1 month
- 1-3 months
- 3-6 months
- 6-12 months
- 1-2 years
- 3-5 years
- 5-10 years
- More than 10 years

When are your symptoms the worst?

- Daytime
- Nighttime
- No pattern since symptoms are sporadic

Prior Work up:

Have you had allergy skin testing done by an allergist in the past? Yes or No

Have you been treated by an allergist in the past 5 years? Yes or No

Have you already seen any of the following specialists for your symptoms/concerns in the past 6 months?

- ENT
- Dermatologist
- Pulmonology (lung specialist)
- Rheumatologist

Have you already been diagnosed with any of the following medical conditions?

- O Allergic Rhinitis
- O Chronic sinusitis
- O Exercised induced asthma
- O Moderate or severe asthma
- O Eczema or atopic dermatitis
- O Dyshidrotic eczema
- O Fungal skin infections
- O Allergic urticarial (hives)
- O Allergic conjunctivitis
- O Chronic idiopathic urticarial (CIU)
- O Irritant dermatitis
- O Eosinophilic esophagitis
- O Gastrointestinal reflux (GERD)
- O History of adenoidectomy
- O Deviated Septum
- O Enlarged Adenoids
- O Non-allergic (weather induced) rhinitis or vasomotor rhinitis
- O Nasal Polyps
- O Mild asthma
- O Oral steroid dependent asthma
- O Dermatographias
- O Nummular Eczema
- O Keratosis Pilaris
- O Hives due to pressure/friction on skin or heat/cold induced
- O Contact dermatitis
- O Food allergies
- O Laryngeal reflux (LPR)
- O History of tonsillectomy
- O History of sinus surgery
- O Enlarged turbinate
- O Enlarged tonsils

Please indicate your most important symptoms of concern and the reason for your visit:

Do you have nasal/sinus concerns? Yes or No

If *yes only*, what are your symptoms?

- O Sneezing
- O Postnasal Drip
- O Ear pain
- O Sinus pressure
- O Recurrent sinus infections
- O Constant phlegm
- O Runny nose
- O Sore Throat
- O Ear fullness
- O Sinus headaches
- O Dry Cough less than 6 months
- O Recurrent bloody nose
- O Nasal Congestion
- O Itchy Throat
- O Ear ringing
- O Recurrent ear infections
- O Throat clearing

When are your nasal/sinus symptoms?

- O Seasonal (warmer months)
- O Late fall/winter
- O Year Around
- O Affected by barometric pressure or sudden temperature changes

Are your nasal/sinus issues worse or effected by non-allergic irritants? Yes or No

If *Yes only*, what irritants effect your nasal passages/sinuses?

- Exercise
- Rain
- Perfumes
- Fans
- Incense and air deodorizers
- Open windows
- Cut grass scent
- Cooking fumes
- Humidity
- Wind
- Cleaning products
- Fertilizer
- Newspaper print
- Paint Fumes
- Cut flowers scent
- Swimming
- Dry heat
- Cold air
- Forced ventilation/heating ducts
- Smoke or bonfires
- Fresh or pine tree
- Diesel exhaust
- Feather pillows
- Detergents

What medications have you tried daily for your nasal symptoms/concern?

- Zyrtec
- Xyzal
- Nasacort nasal spray
- Flonase/fluticasone nasal spray
- Rhinocort nasal spray
- Over the counter cold and sinus medication(s)
- Allegra
- Benadryl
- Sinus rinse or Neti-pot
- Nasonex nasal spray
- Azelastine or Asetpro nasal spray
- Claritin
- Sudafed
- Saline Nasal spray

Do you have any eye concerns? Yes or No

If *yes only*, what are your symptoms?

- Itchy eye
- Swollen eyes
- Burning/ stinging eyes
- Watery eyes
- Eyelid rashes
- Red eyes
- Dry eyes

Any chronic breathing issue or concerns? Yes or No

If *yes only*, what are your symptoms?

- Chronic dry cough for more than 6 months
- Wheezing
- Recurrent bronchitis
- Shortness of breath or chest tightness with exercise – indoor or outdoor
- Productive mucous cough
- Chest tightness
- Nighttime awaking with cough
- Shortness of breath or chest tightness with outdoor exposure only
- Shortness of breath at rest during the day
- Chest congestion
- Nighttime wheezing and/or shortness of breath
- Worsening asthma symptoms

Have you tried any of the following medications for your lungs/breathing?

- Proair or Albuterol inhaler
- Dulera inhaler
- Symbicort inhaler
- Advair inhaler
- Breo inhaler
- Trelegy inhaler
- Spiriva inhaler
- Singulair/ Montelukast
- Over the counter cold and cough medication
- Flovent inhaler
- Qvar inhaler
- Anti-histamines
- Decongestants
- Saline nasal spray
- Flonase/Fluticasone nasal spray
- Nasonex nasal spray
- Nasacort nasal spray
- Sinus irrigation rinsing (sinus rinse) or Netipot
- Oral Steroids
- Pulmicort inhaler
- Xolair

Do you have a diagnosis of asthma? Yes or No

If *Yes only*:

Do you take a daily steroid inhaler for your asthma symptoms? Yes or No

Have you had an asthma attack requiring urgent care or an ER visit in the past 1 year? Yes or No

Have you required oral steroid within the past 6 months for asthma? Yes or No

Do you have any skin concerns or allergic reactions: Yes or No

If *yes only*, what are your symptoms?

- Itchy skin (no rash)
- Chronic itchy rash
- Seasonal rash
- Skin swelling on hands and feet
- Face, lip, or eye swelling
- Throat or tongue swelling
- Hives
- Anaphylaxis
- Eczema
- Dermatographism (raised red streaks on skin from scratches)
- Stinging or burning of the skin
- Other skin issues, please explain: _____

How long have you had skin or allergic reactions?

- Less than a month
- 1-3 months
- 6 months – 1 year
- 1-2 years
- 3-5 years
- Several years
- Occurs sporadically

Do you take an anti-histamine one to three times a day for prevention of skin issues or an allergic reactions? Yes or No

Do you take a Pepcid/Famotidine daily for your skin or an allergic reaction? Yes or No

Have you had to use an Epipen for an allergic reaction? Yes or No

Have you been to the ER for an allergic reaction or severe skin reaction in the past 6 months? Yes or No

Have you needed oral steroids (prednisone or Medrol dose pack) for an allergic reaction, hives or eczema within the past 3 months? Yes or No

***Non- Allergic Triggers: Are your nasal, breathing, eye and/or skin issues worse or effected by non-allergic irritants (these are not due to an allergy)*:** Yes or No

If *Yes only*, what irritants effect your nasal passages/sinuses?

- Exercise
- Sun exposure
- Cold air
- Forced ventilation/heating ducts
- Smoke or bonfires
- Newspaper print
- Paint fumes
- Cut flowers scent
- Swimming
- Hot showers
- Shampoos
- Hair dye
- Dental floss
- Acrylics
- Wool or acrylic clothing
- Humidity
- Rain
- Perfumes
- Fans
- Incense and air deodorizers
- Fresh or pine tree
- Diesel exhaust
- Feather pillows
- Laundry detergents
- Skin care products with fragrance
- Shaving cream
- Toothpaste
- Mouthwash
- Shaving cream
- Fleece blanket
- Dry heat
- Wind
- Cleaning products
- Fertilizer
- Candles
- Open windows
- Cut grass scent
- Cooking fumes
- Fabric softeners
- Body wash and soaps
- Facial and eye make up
- Toothbrush
- Nail polish
- Pressure or friction applied to the skin

***Do you have any gastrointestinal (GI) symptoms*:** Yes or No

If *yes only*, what are your symptoms?

- Reflux
- Nausea
- Abdominal bloating
- Diarrhea
- Constant throat clearing and phlegm in throat
- Vomiting
- Constipation
- Irritable bowel syndrome

Do you have any concerns for food allergies or are you avoiding any foods? Yes or No

If *yes only,* what foods are you avoiding?

- Wheat
- Potatoes
- Peanuts
- Shellfish
- Strawberries or berries
- Bananas
- Other foods (please list):
- Soy
- Dairy
- Tree nuts
- Tomatoes
- Melons
- Carrots
- Corn
- Eggs
- Fish
- Oranges
- Apples
- Squash or zucchini

Do you avoid food dyes and additives? Yes or No

If *yes only*, which ones do you avoid (please list)?

_____

Have you been diagnosed with food allergies based on allergy testing in the past? Yes or No

If *yes only*, what foods were you confirmed to be allergic to?

- Wheat
- Potatoes
- Eggs
- Fish
- Strawberries or berries
- Banana
- Oat
- Soy
- Peanut
- Shellfish
- Melons
- Carrots
- Corn
- Milk
- Treenut
- Tomatoes
- Apples
- Squash or zucchini

Other foods (please list): _____

Have you had an anaphylactic reaction to foods? Yes or No

Have you needed oral steroids for an allergic reaction to foods? Yes or No

Do you carry an epinephrine (Epi-pen) with you for food allergies? Yes or No

***Have you had an anaphylactic reaction or severe allergic reaction (more than just a large localized area of swelling) requiring you to go to the ER for a bee or wasp sting*?** Yes or No

If *yes only*, what was the sting from?

- Honeybee
- Hornet
- Wasp
- Yellowjacket

Have you been prescribed an epinephrine (Epi-pen) for a severe stinging insect allergy? Yes or No

Environmental History:

How old is your dwelling?

- New construction
- 1 year old
- 2-5 years
- 6-10 years
- 11-19 years
- 20-30
- More than 30 year

Do you live in an apartment? Yes or No

Do you own your home? Yes or No

Do you have pets? Yes or No

If Yes only, how many of each?

- Cats # _____
- Dogs # _____
- Rabbits # _____
- Birds # _____
- Guinea pigs # _____

Do you have carpeting in the bedrooms and/or living areas? Yes or No

Do you have central heat? Yes or No

Do you have central A/C? Yes or No

Do you have a central air purifier or an individual bedroom unit? Yes or No

History of flooding in home? Yes or No

Have you had remodeling done in your home within the past 5 years? Yes or No

Have you had your air ducts cleaned out in the past 3 years? Yes or No

Thank you for completing this form to help our provider and team better take care of you on your visit to our office.