MORRIS HOSPITAL
ALLERGY SPECIALISTS

Allergy New Patient History Form

Patient Name: _____

Date of Birth: _____

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

_____

_____

_____

_____

How long have you been having this problem?

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

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

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

When are your symptoms the worst?

- O Daytime
- O Nighttime
- O 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?

- O Dermatologist
- O ENT
- O Gastroenterology (GI)
- O Pulmonology
- O Rheumatologist

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

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

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 Constant phlegm
- O Dry cough less than 6 months
- O Ear fullness
- O Ear pain
- O Ear ringing
- O Itchy Throat
- O Nasal congestion
- O Postnasal drip
- O Recurrent bloody nose
- O Recurrent ear infection
- O Recurrent sinus infection
- O Runny nose
- O Sinus headaches
- O Sinus pressure
- O Sneezing
- O Sore throat
- 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?

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

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

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

Do you have any eye concerns? Yes or No

If *yes only*, what are your symptoms?

- O Itchy eye
- O Watery eyes
- O Red eyes
- O Swollen eyes
- O Eyelid rashes
- O Dry eyes
- O Burning/ stinging eyes
- O Other: _____

Any chronic breathing issue or concerns? Yes or No

If *yes only*, what are your symptoms?

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

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

- O Advair inhaler
- O Albuterol or Proair
- O Anti-histamines
- O Breo inhaler
- O Decongestants
- O Dulera inhaler
- O Flonase/Fluticasone nasal spray
- O Flovent inhaler
- O Nasonex nasal spray
- O Oral steroids
- O Over the counter cold and cough meds
- O Pulmicort inhaler
- O Qvar inhaler
- O Saline nasal spray
- O Singulair/Montelukast
- O Sinus irrigation rinsing
- O Spiriva inhaler
- O Symbicort inhaler
- O Trelegy inhaler
- O Xolair
- O Other: _____

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?

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

_____

How long have you had skin or allergic reactions?

- O Less than a month
- O 1-3 months
- O 6 months – 1 year
- O 1-2 years
- O 3-5 years
- O Several years
- O 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?

- O Acrylics
- O Body wash and soaps
- O Cleaning products
- O Cold air
- O Cooking fumes
- O Cut flowers scent
- O Cut grass scent
- O Dental floss
- O Diesel exhaust
- O Dry heat
- O Exercise
- O Fabric softeners
- O Facial and eye make up
- O Fans
- O Feather pillows
- O Fertilizer
- O Fleece blanket
- O Forced ventilation/heating ducts
- O Fresh pine tree scent
- O Hair dye
- O Hot showers
- O Humidity
- O Incense and air deodorizers
- O Laundry detergents

***** Continued on next page*****

- O Mouthwash
- O Nail polish
- O Newspaper print
- O Paint fumes
- O Perfumes
- O Pressure or friction applied to the skin
- O Rain
- O Shampoos
- O Shaving cream
- O Skin care products with fragrance
- O Smoke or bonfires
- O Swimming
- O Toothbrush
- O Toothpaste
- O Wind
- O Wool or acrylic clothing

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

If *yes only*, what are your symptoms?

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

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?

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

_____

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?

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

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
- Wasp
- Hornet
- 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 years
- More than 30 years

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 # _____
- Other & # _____

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.

_____ _____

Signature **Date**