

H. TERRY LEVINE, M.D., FACP, FAAAAI, FAAAAI
CERTIFIED-AMERICAN BOARD OF ALLERGY
AND IMMUNOLOGY
CERTIFIED-AMERICAN BOARD OF INTERNAL MEDICINE (89)

ALLERGY & ASTHMA CARE, P.A.
ALLERGY, ASTHMA AND RELATED DISEASES
www.allergycarekc.com

NGUYEN P. TRAN, M.D., FAAAAI
CERTIFIED-AMERICAN BOARD OF ALLERGY
AND IMMUNOLOGY
CERTIFIED-AMERICAN BOARD OF INTERNAL MEDICINE (09)
CERTIFIED-AMERICAN BOARD OF PEDIATRICS (10)

CELINA C. BERNABE, D.O., FAAAAI
CERTIFIED-AMERICAN BOARD OF ALLERGY
AND IMMUNOLOGY
CERTIFIED-AMERICAN BOARD OF INTERNAL MEDICINE (98)
CERTIFIED-AMERICAN BOARD OF PEDIATRICS (00)

CORI COPILEVITZ PASSER, M.D., FAAAAI
CERTIFIED-AMERICAN BOARD OF ALLERGY
AND IMMUNOLOGY
CERTIFIED-AMERICAN BOARD OF INTERNAL MEDICINE (01)

SARA D. POWELL, M.D.
CERTIFIED-AMERICAN BOARD OF ALLERGY
AND IMMUNOLOGY
CERTIFIED-AMERICAN BOARD OF INTERNAL MEDICINE (16)

10787 NALL AVE. • SUITE 200 • OVERLAND PARK, KS 66211 • (913) 491-3300 • FAX (913) 491-0904

Note: You must bring this questionnaire to your appointment.

(If there is a question you do not understand, place a question mark by it in the margin.)

Name _____ DOB _____ Age _____ Date _____

Person completing questionnaire if not the patient _____ Relationship _____

Spring Fall

circle the symptomatic months: Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec year-round symptoms

Check current and/or recent symptoms : (Please be as complete as possible.)

ROS:

Eyes: burning itching watering redness swelling shiners (dark circles under eyes) dryness discharge visual problems

ENT:

ears: itching pain infections tubes (year(s) _____) popping hearing loss fullness

nose: itching sneezing congestion (worse in the: AM PM all day) drainage (color _____)

postnasal drip snoring runniness sleep apnea blood decreased smell

throat: soreness redness itching mucus throat clearing hoarseness bad breath

Resp: cough (worse in the: AM PM all day, cough wakes patient up at night (# of times waking up _____),

cough is: dry moist (color of discharge _____) cough is worse with exercise,

cough is worse with laughter, cough is worse with crying, cough is worse: lying down upright)

wheezing year of last chest X-ray _____ results of last chest X-ray _____

CV: tightness in the chest shortness of breath palpitations chest pain (location _____)

tobacco: cigarettes (number of packs per day _____ years smoked _____ year quit _____) cigars pipes

smokers in the home presently/previously (who _____) smokeless tobacco (chew)

electronic cigarette (vapor)

GI tract: heartburn/stomach reflux: worse in the: AM PM after meals all day, heartburn/reflux makes the cough worse

hiatal hernia nausea vomiting diarrhea constipation pain (frequency _____)

Neuro: headache: dull throbbing pressure (forehead cheeks between the eyes behind the eyes)

temples "band-like" around head back of the head migraines vertigo loss of consciousness

Const: fevers chills body aches weakness sleeps poorly at night (# of times waking up per night _____)

Skin: eczema rash hives swelling itching dry skin (location _____)

All/Imm: insect reactions to: bees wasps hornets fire ants mosquitoes chiggers

with reactions, was there associated: large local swelling hives wheezing throat swelling nausea/diarrhea

unconsciousness emergency treatment required age at time of reaction _____

recurrent infections food reaction facial rash mouth ulcers dry eyes severe sun sensitivity

Psych: stress anxiety depression insomnia

Endo: fatigue sweats hot flashes unintentional weight loss weight gain goiter excessive hair loss

nursing pregnant planning pregnancy; when _____

Mus/Skel: joint pain joint swelling muscle pains muscle weakness muscle wasting leg swelling

Gen/Urin: blood in the urine foamy urine painful urination incontinence bedwetting

Past Medical History: (If patient is a child, please complete birth information below)

- birth weight _____ lbs. _____ oz. pregnancy complications delivery complications
- vaginal delivery C-section premature full term
- breast fed (how long? _____) formula fed (milk soy) colic feeding problems
- recurring infections (ear sinus tonsil throat chest skin)
- school problems _____

(All patients should answer the following questions):

- immunizations: unknown DTP (year of last tetanus immunization _____) IPV (polio) MMR (mumps measles rubella)
- HIB (Haemophilus influenza B) hepatitis vaccine HPV Pneumovax 23 (year _____)
- Prevnar 13 (year _____) flu vaccine (year of last shot _____) reactions: _____

Medical History:

Surgical History:

Present Medications: (including over-the-counter and supplement medications)

<u>list major illnesses or diseases</u>	<u>year</u>	<u>procedure</u>	<u>list names of medications</u>	<u>dosage</u>	<u># times per day</u>
1)	1)	_____ tonsillectomy & adenoidectomy	1)		
2)	2)		2)		
3)	3)		3)		
4)	4)		4)		
5)	5)		5)		
6)	6)		6)		
Please list any recent antibiotics prescribed in the past year (for respiratory issues)			7)		
<u>list names of medications</u>	<u>dates</u>	<u>dosage</u>	<u># times per day</u>	8)	
1)				9)	
2)					
3)					

hospitalizations:

Family History: marital status: (marital status of the parent if the patient is under 18) M S D W Sep

If patient is an adult:

For all patients:

<u>age</u>	<u>name</u>		<u>age</u>	<u>name</u>
Patient's children:	1)	Please list patient's brothers and/or sisters:	1)	
	2)		2)	
	3)		3)	
	4)		4)	
	5)		5)	

check illnesses present in immediate family members (blood relatives)

- asthma hay fever or nasal allergy eczema hives food allergy insect allergy medication allergy

List Family Member: _____

(Draw arrows to family members with illnesses checked.)

- lung disease heart disease diabetes cancer (type: _____) immune disorder
- other _____

Environmental History:

home: townhouse apt house (age_____yrs, occupied by patient_____yrs) city/suburb country/farm
basement is: dry damp musty poured concrete rock/stone concrete block
basement is finished dehumidifier is used in basement crawl space slab

windows: windows open during the spring summer fall never

attic fan: the attic fan is used in the: spring summer fall never used attic fan use makes symptoms **worse**

heating: natural gas (forced air) electric wood LP gas oil

humidifier: attached on furnace free-standing (location_____)

air conditioning: central window units (window unit in patient's bedroom) air conditioning makes symptoms **better**

air filter: disposable (how often is it changed?_____) HEPA filter electronic electrostatic

bedroom: location (above ground basement) wall-to-wall carpeting hardwood floor area rug

pillow: feather synthetic/foam (number of pillows_____, how old_____yrs) special allergy proof covers over pillows
spouse's pillow: feather synthetic/foam (number of pillows_____, how old_____yrs.)

mattress: inner spring mattress (age of mattress?_____yrs) foam Tempurpedic (age of mattress?_____yrs)
sleep number bed special allergy proof cover over mattress (zippered type) plastic cover on mattress futon

mattress pad: what temperature water is the mattress pad washed in?: hot warm cold
cotton (washed how often_____) feather mattress pad egg-crate mattress pad

sheets: washed how often_____, what temperature water are the sheets washed in?: hot warm cold

bed cover: comforter (feather fill synthetic/fiber fill cotton) blanket quilt bedspread

pets: cats (number_____ indoor outdoor), dogs (number_____ indoor outdoor), other pets_____

Where do the pets sleep at night? _____ Do the pets get into bedroom on bed

Diet: Do you/patient eat: chocolate ___/ 7 days peppermint ___/ 7 days fatty foods ___/ 7 days spicy foods ___/ 7 days
tomato products ___/ 7 days citrus juice___/ 7 days?

Do you/patient eat 2-3 hours before bed? drink water or fluid 30 min before bed? If so, how much?___oz. water at bedside?

Social History:

alcohol: beer wine liquor (drinks per week_____) tobacco: see HPI illicit drug use: _____

caffeine: tea (cups per day___ caf decaf) coffee (cups per day___ caf decaf) soda (# per day___ caf caffeine free)
energy drinks (# per day___)

Occupation (or school & grade if a student): patient' _____ spouse _____
(if infant/child: mother's occupation_____ father's occupation_____)

daycare/preschool: where _____ daycare hours _____ number of children present _____

hobbies/crafts: _____

Clinical Disagreements: (Please check the items that make you/the patient's symptoms worse)

Nasal/sinus symptoms are worsened by: smoke aerosols dust perfumes basements cats dogs cold air wind
beer wine(red white) rain humidity temperature changes season changes weather changes other_____

Lung symptoms are worsened by: smoke aerosols dust perfumes basements cats dogs cold air wind
beer wine(red white) rain humidity temperature changes season changes weather changes

exercise respiratory infections laughing crying aspirin products salad bars heartburn/reflux other_____

Skin symptoms are worsened by: poison ivy/oak/sumac cut grass leaves plants cosmetics
soaps wool others_____

List food and reaction(s): _____

Drug Disagreements or Reactions: (Please list all reactions.)

<u>Year</u>	<u>Medication</u>	<u>Reaction</u>
1)		
2)		
3)		
4)		
5)		
6)		

Please list brand names of products the patient uses:

soap _____ shampoo _____ conditioner _____
detergent _____ fabric softener _____ toothpaste _____
hairspray _____ cosmetics _____
hair gel _____ perfumes or colognes _____ moisturizer _____

Skin History: (Fill out only if experiencing skin problems)

Hives and/or rash and/or swelling/angioedema:

features: date of onset _____ worse in: AM PM all day after meals
itching present affected areas: arms hands legs feet stomach back head/face
appearance: red flat raised blistery leaves marks/bruises hives/rash move around
hives/rash stay in one spot how long do the hives/rash last? _____
hives or rash is described as mild moderate severe

triggers: heat exercise sunlight cold water pressure vibration rubbing/scratching
contact (what material/plant/food/animal/cosmetic? _____)
menstrual cycle/hormones stress food (which ones? _____)
infections/colds/flu medication (which one? _____)

symptoms: recent cold or flu joint pains joint swelling sun sensitivity facial rash fever foamy urine
blood in the urine hair loss abdominal pain fatigue mouth sores facial/sinus pain or pressure
nasal congestion postnasal drip sinus pressure/headache tooth pain
weight gain weight loss goiter diarrhea shakiness hot flashes

new medications (prescription or over-the-counter) _____

new foods _____