The Virginia Center for Allergy & Asthma

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NEW PATIENT QUESTIONNAIRE

Patient Name: _____ **DOB**: _____ **Age:** _____ **PCP:**_____

REASON FOR TODAY'S VISIT:

_____

CURRENT MEDICATIONS: please list ALL medications you take (include over-the-counter, vitamins, herbals)

Medication	Dose	Frequency

Have you ever had a suspected allergic reaction to any of the following below? If so, please describe below.

Medication(s)/reaction:
Food(s)/reaction:
Insect sting(s)/reaction:
Latex product(s)/reaction:

Do you carry an Epi-Pen? □ No □ Yes

PAST MEDICAL HISTORY Please list any chronic medical conditions you have had (include hypertension, diabetes, acid reflux, thyroid disorder, cancer, etc.)	PAST SURGICAL HISTORY Please list any past surgeries you have had with the approximate date (include tonsils/adenoid removal, sinus surgery, gallbladder removal, C-section, etc.)

FAMILY HISTORY: please check all pertinent conditions for your immediate family members.

Relative	Environmental allergy ("hay fever)	Asthma	Eczema	Food Allergy	Medication Allergy	Hives/Swelling	Other (please list high blood pressure, diabetes, cancer, etc)
Mother							
Father							
Sibling(s)							

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IMMUNIZATION HISTORY:

Have you had the flu shot?	□ Yes □ No □ Not Sure If yes, date received:
Have you had the pneumonia shot? (Pneumovax)?	□ Yes □ No □ Not Sure If yes, date received:

ENVIRONMENTAL HISTORY:

Type of housing/setting	□ House □ Apartment □ Mobile home □ Condominium □ Other Number of years living in this location:
Type of flooring in residence	□ Hardwood □ Carpet □ Tile □ Linoleum □ Area rugs □ Other
Pets	□ Yes □ No If yes, please describe type and # of pet(s):
Heating/cooling system	□ Central air/heat □ Window units □ Space heater □ Ceiling Fans □ Other
History of flooding/water leaks?	□ Yes □ No
Visible mold/mildew	□ Yes □ No
Use of dust mite encasings on mattress/pillows	□ Yes □ No

SOCIAL HISTORY:

Tobacco use/exposure	□ Never smoked □ Current daily smoker □ Former smoker □ Current some day smoker (social) □ Unknown if ever smoked **If current/former smoker:** Type: □ cigarettes □ cigars □ chewing □ pipe □ snuff □ smokeless Packs/units per day: _____ Years used: _____ Ever tried to quit? Y/N Year quit: _____
Passive/second hand smoke exposure	□ No □ Yes If yes, where: _____
Alcohol use	□ No □ Yes If yes, how often: □ rarely □ weekly □ daily □ socially
History of illicit drug use/substance use	□ No □ Yes If yes, how often: □ rarely □ weekly □ daily □ socially
Employment Status	□ Current Employed (list occupation:_____) □ Not Employed □ Student □ Retired (list occupation:_____)

PEDIATRIC PATIENTS ONLY

School/daycare attendance	□ Yes □ No Name of school/daycare:_____ If yes, how many days a week: _____
Birth	□ Premature □ Full term □ Vaginal □ C-section
Breastfeeding	□ Yes □ No If yes, for how long:_____
Formula feeding	□ Yes □ No If yes, what formula base is being used? □ Milk □ Soy □ Other
Immunizations up to date	□ Yes □ No