



**All Current Medicines:**

**PHYSICIAN NOTES**

number of mg, tabs,  
caps, or inhaler puffs

_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____
_____	_____	_____ times per day	_____

**Previous allergy or asthma medications (including OTC):**

_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____
_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____
_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____
_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____
_____	<input type="checkbox"/> helped	<input type="checkbox"/> no help	_____

**Past Medical History:**

Birth Weight: \_\_\_\_\_ Problems at Birth? YES / NO

**Surgeries:**

(Age or year)

_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____

**Hospitalizations (other than surgery):**

(Age or year)

_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____

**Drug Allergies:**

_____	caused	_____	_____
_____	caused	_____	_____

**Immunization Adverse Reactions:**

_____	caused	_____	_____
_____	caused	_____	_____

**Past Allergy History:** (use space at right if needed)

YES NO

Previous allergy testing (If 'yes' then answer the questions below)

Testing by Dr. \_\_\_\_\_ Year \_\_\_\_\_

Previous allergy shots

Currently on allergy injections every \_\_\_ weeks

**Do You Have:**

YES NO

YES NO

Cats   Cigarette smoke

Dogs   Wood burning stove

Birds   Damp basement

Other pets: \_\_\_\_\_   Mold growth

Feather pillow   Room air cleaner

Down comforter   Whole house air cleaner

Bedroom Carpet Workplace: \_\_\_\_\_



# **FOOD ALLERGY QUESTIONNAIRE**

Please use ONE FORM PER FOOD

Name of food \_\_\_\_\_

When did you eat it last and reacted \_\_\_\_\_

How much food was eaten \_\_\_\_\_

What was the reaction \_\_\_\_\_

\_\_\_\_\_

How many minutes or hours after eating did the reaction start \_\_\_\_\_

How long did the reaction last \_\_\_\_\_

How did you treat/manage the reaction \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

How many times have you had the reaction \_\_\_\_\_

Did you go to the ER \_\_\_\_\_

\_\_\_\_\_

Did you try the same food again \_\_\_\_\_

Which foods are you currently strictly avoiding \_\_\_\_\_

\_\_\_\_\_

Do you have Epi-Pen or Auvi-Q \_\_\_\_\_

Do you have an Anaphylaxis Action Plan \_\_\_\_\_

What are the goals of your visit today \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

## Hives/ Itching

How long have you had it \_\_\_\_\_ How often do you get it (weekly daily, etc) \_\_\_\_\_

How long does it lasts once it comes \_\_\_\_\_ Itching present or not \_\_\_\_\_

Do you have any pain or burning with hives \_\_\_\_\_

How does it look to you \_\_\_\_\_

What body parts affected? Is it all over the body? Head/scalp? \_\_\_\_\_

When it goes away, does it leave any mark behind \_\_\_\_\_ Are you under high stress \_\_\_\_\_

Do you take OTC pain killers- like ibuprofen, etc.? How often? \_\_\_\_\_

What medications have you tried? Did they help? \_\_\_\_\_

Did you see a dermatologist \_\_\_\_\_

Did you have any blood tests done \_\_\_\_\_

Do you have exposure to new contacts, environments or medications \_\_\_\_\_

Do you have other symptoms like nausea, abdominal pain, fever, weight loss, etc. \_\_\_\_\_

Do you get lip swelling, face swelling, throat closing? How often? \_\_\_\_\_

How often have you been to the ER \_\_\_\_\_

What are the goals of your visit \_\_\_\_\_

## COUGH QUESTIONNAIRE

How long have you had a cough? \_\_\_\_\_

Is the cough daytime or nighttime or both? \_\_\_\_\_

Does the cough wake you up at night? \_\_\_\_\_

Any blood or mucus? Is the cough wet or dry? \_\_\_\_\_

\_\_\_\_\_

Have you had a chest xray? If so, when and where? \_\_\_\_\_

\_\_\_\_\_

Have you had a CT of the chest? If so, when and where? \_\_\_\_\_

\_\_\_\_\_

Have you had a CT of the sinus? If so, when and where? \_\_\_\_\_

\_\_\_\_\_

Have you seen any specialists, such as Ear Nose and Throat, Pulmonology (lung) Gastroenterology?

Which ones? \_\_\_\_\_

\_\_\_\_\_

Which medications have you tried? \_\_\_\_\_

\_\_\_\_\_

Do you have heartburn/reflux issues? \_\_\_\_\_

What triggers your cough? \_\_\_\_\_

\_\_\_\_\_

Does it feel to you that the cough is coming from the throat or the chest area? \_\_\_\_\_

Are you taking any painkillers, aspirin, blood pressure or diabetes medications? \_\_\_\_\_

\_\_\_\_\_

Do you snore? \_\_\_\_\_

What are the goals of your visit today \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_