

REGIONAL

ALLERGY & ASTHMA
 IMMUNOLOGY CENTER

CHART # _____

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Patient: _____ DOB: _____ Age: _____
 Date: _____ Ethnicity: White African-American Asian Hispanic Other
 Accompanied by: _____ Referring Physician: _____
 Primary Care Physician: _____ Reason for Visit: _____

Section A- Allergy Symptoms – Check ALL that apply- (If no allergy symptoms, proceed to Section B)

- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Itchy ears | <input type="checkbox"/> Runny nose | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Sore throat |
| <input type="checkbox"/> Popping in ears | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Watery eyes | <input type="checkbox"/> Throat clearing |
| <input type="checkbox"/> Ear pain | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Red eyes | <input type="checkbox"/> Hoarseness |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Itchy nose | <input type="checkbox"/> Swollen/puffy eyes | <input type="checkbox"/> Loss of taste |
| <input type="checkbox"/> Fluid in ears | <input type="checkbox"/> Postnasal drip | <input type="checkbox"/> Dark circles under eyes | <input type="checkbox"/> Difficulty swallowing |
| <input type="checkbox"/> Ear drainage | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Eye drainage | <input type="checkbox"/> Headache |
| | <input type="checkbox"/> Decreased sense of smell | | <input type="checkbox"/> Sinus pain/pressure |
| | <input type="checkbox"/> Snoring | | <input type="checkbox"/> Sinus infections |

When did your symptoms begin? _____

Worse in? Spring Summer Fall Winter All Year

How long have you had symptoms? _____ Are your symptoms getting worse? Y / N

Degree of symptoms? Mild Moderate Severe

Do they interfere with daily activities? Y / N

Where and when do your symptoms occur? Outdoors Indoors Home Work School
 Night Day Other

Which of the following make your symptoms worse? Pollen Grass Leaves Hay
 Cat Dog Dust Mold/Mildew Basements Horses Birds/Feathers
 Livestock Tobacco Smoke Pollution Aerosol sprays Perfumes Jewelry Colds/Viruses
 Air Condition/Heating Hot Weather Cold Weather Humidity Changes in Weather
 Other _____

Patient: _____ Chart: _____ DOB: _____

What makes your symptoms better? OTC Meds Prescription Meds Nasal Spray
 Antibiotics Steroids Travel Air Condition Rest Other _____

Have you missed school/work due to your symptoms? Y / N Number of days missed on average? _____

Have you ever had Allergy Testing? Y / N Skin Test Blood Test

How long ago was Allergy Testing performed? Less than 1 year 1-3 years 4+ years
 Don't remember Did you every receive Allergy Shots? Y / N

Section B: Asthma Symptoms- Check All that apply-(If no asthma symptoms, proceed to Section C)

Do you experience any of the following?

- Cough Symptoms with infections/colds Bronchitis
- Wheezing Symptoms with exercise Chest colds
- Shortness of Breath Symptoms at night History of RSV in infancy
- Chest Tightness Symptoms during the day Recurrent pneumonia
- Productive Cough Recurrent walking pneumonia

Are the above symptoms getting worse? Y / N How long have you had symptoms? _____

Do you consider your symptoms to be Mild Moderate Severe?

Which of the following make your Asthma Symptoms worse?

- Colds Infections Exercise Animals Sinusitis Pollen Mold/Mildew Dust
- Reflux Cold Air Cigarette Smoke Changes in Weather Other _____

How often do you require a Rescue Inhaler for your Asthma Symptoms?

- Never 1-2 x per week 3-4 x per week Daily More than once a day

How often in a typical week do your Asthma Symptoms wake you at night?

- Never 1-2 x per week 3-4 x per week Daily

In the past one (1) year, have you required steroids (oral, injectable)? Y / N

- How often? Once Two (2) times More than Three (3) times

Have you required any ER visits or Urgent Care visits due to Asthma Symptoms in the past one (1) year?

- Never 1 time 2 times 3 times More than 3 times

Have you required any hospitalizations due to Asthma Symptoms in the past one (1) year? Y / N

If yes, how many times? _____ ICU admissions? Y / N Intubations? Y / N

Patient: _____ Chart: _____ DOB: _____

Section C - Sinus Issues/Headaches (If none of these symptoms, proceed to Section D)

Do you have Sinus problems? Y / N Number of Sinus Infections in past one (1) year? _____

Have you ever had an X-Ray or CT scan of your sinuses? Y / N

Have you ever had Sinus Surgery? Y / N Nasal Polyps? Y / N

Do you experience Headaches? Y / N How often do you have Headaches? Daily Weekly
 Monthly

How long do your Headaches last? Hours Days

Have you missed any school/work due to headaches? Y / N

What makes your Headaches better? Rest OTC Meds Prescription Meds
 Other _____

Section D- Skin Symptoms: (If no skin symptoms, proceed to Section E)

Do you experience any of the following: Rash Itching Eczema Hives Dry Skin
 Swelling of lips/face Skin Infections

Where do the Skin Rashes occur? _____

How long have you experienced Skin Symptoms? _____

Are Skin Symptoms getting worse? Y / N How often do Skin Symptoms Occur? _____

Have you been seen in Urgent Care or MD's office for your Skin Symptoms? Y / N

Have you required Steroids (oral, injectable, topical) for your Skin Symptoms? Y / N How Often? _____

Which of the following make Skin Symptoms worse? Heat Cold Food Pets Metals
 Plants Medications Cosmetics Exercise Dry Weather Cleaning Supplies

What makes Skin Symptoms better? Steroid creams Antibiotics Lotion/Creams
 OTC Medications Oral/Injectable Steroids Avoidance of Food

Patient: _____ Chart: _____ DOB: _____

Section E- Abdominal Symptoms : (If no abdominal symptoms, proceed to Section F)

Do you have any of the following: Abdominal Pain Constipation Diarrhea Nausea
 Heartburn/Reflux Vomiting Bloating - Other _____

Section F- Other Allergy History : Check ALL that apply

Do you get a rash with exposure to Poison Ivy Poison Oak Poison Sumac?

Do you have a Food Allergy or Food Intolerance? Y / N (Please list suspected foods/reaction below)

Do you have a Latex Allergy? Y / N Type of Reaction? _____ When? _____

Do you have a Stinging Insect Allergy? Y / N (Please check insect/reaction below)

Honey Bee Reaction: _____ When? _____

Wasp Reaction: _____ When? _____

White-faced hornet Reaction: _____ When? _____

Yellow hornet Reaction: _____ When? _____

Yellow jacket Reaction: _____ When? _____

Mosquito Reaction: _____ When? _____

Fire Ant Reaction: _____ When? _____

Have you ever been prescribed Epi-Pen (self-injectable epinephrine)? Y / N

Section G: Immune Problems

Do you receive an annual Flu Shot ? Y / N Have you ever had a Pneumonia Shot? Y / N When? _____

Are your immunizations up to date? Y / N Do you have recurrent infections? Y / N

How often do you have infections? Less than once a year 2-3 x per year 3-4 x per year

Have you been diagnosed to have an "Immune Deficiency"? Y / N