Riverview Health Physicians Allergy & Immunology

17600 Shamrock Blvd, Suite 500A,
Westfield, IN 46074
T 317.214.5725

New Patient Questionnaire

Please complete within three days of your appointment.

Name: _____ **Date of Birth:** _____

Appointment Date: _____

What is the reason for your visit?

_____

_____

_____

NOSE AND EYES:

Please mark the season(s) during which you have been experiencing the following symptoms:

	Spring	Summer	Fall	Winter	Year-round
Runny nose					
Stuffy nose					
Post-nasal drainage					
Itchy nose					
Sneezing					
Morning sore throat					
Sinus/facial pressure					
Wheezing/shortness of breath					
Watery eyes					
Red eyes					
Itchy eyes					

Do your symptoms improve on vacation? Yes No

Is your nasal congestion/stuffiness worse on the: Left Right Equal

Riverview Health Physicians Allergy & Immunology

17600 Shamrock Blvd, Suite 500A,
Westfield, IN 46074
T 317.214.5725

Please circle any triggers you have noticed for the above symptoms:

- **Irritants:** Detergents/soap Cooking odors Perfumes/strong odors Smoke
- **House dust:** Dusting Vacuuming
- **Molds:** Cutting grass Raking leaves Basements
- **Pets/animals:** Dogs Cats Other: _____
- **Weather:** Hot Cold Humid Damp Weather changes
- **Other (e.g. medications, workplace):** _____

SINUSES:

How often do you have sinus infections? _____

What symptoms do you have with a sinus infection (circle all that apply)?

- Decreased sense of smell or taste Bad breath
- Facial pressure Green/yellow drainage

Any history of sinus surgery? _____

LUNGS:

Have you been diagnosed with asthma? _____

If yes, when/how long ago? _____

Do you take any asthma medications? If so, what?

_____

Have you ever been hospitalized for your asthma? _____

In the past twelve months:

- **Have you seen a doctor for your asthma?** _____
- **Have you been to the emergency room for your asthma?** _____
- **Have you taken oral steroids (prednisone, Medrol dose pack) for your asthma?** _____

Please circle any triggers for asthma that you have noticed:

Weather changes Colds/infections Allergies Medications

Exercise Smoke Strong smells

Riverview Health Physicians Allergy & Immunology
17600 Shamrock Blvd, Suite 500A,
Westfield, IN 46074
T 317.214.5725

If you have asthma, please answer the following questions:

									SCORE
1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?	All of the time	1	Most of the time	2	Some of the time	3	A little of the time	4	None of the time	5	
2. During the past **4 weeks**, how often have you had shortness of breath?	More than once a day	1	Once a day	2	3 to 6 times a week	3	Once or twice a week	4	Not at all	5	
3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?	4 or more nights a week	1	2 or 3 nights a week	2	Once a week	3	Once or twice	4	Not at all	5	
4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?	3 or more times per day	1	1 or 2 times per day	2	2 or 3 times per week	3	Once a week or less	4	Not at all	5	
5. How would you rate your **asthma** control during the **past 4 weeks**?	Not controlled at all	1	Poorly controlled	2	Somewhat controlled	3	Well controlled	4	Completely controlled	5	
											TOTAL

SKIN:

Any history of eczema? _____

If so, where? _____

How do/did you treat it? _____

Any history of hives?

If so, where? _____

How often? _____

How long do individual hives last? _____

Any associated symptoms? _____

How do/did you treat it? _____

Any other skin conditions?

_____

Riverview Health Physicians Allergy & Immunology
17600 Shamrock Blvd, Suite 500A,
Westfield, IN 46074
T 317.214.5725

OTHER ALLERGIES:

Adverse food reactions:

Food	Age/year	Symptoms

Did you require emergency treatment for any of the above reactions? _____

Adverse drug reactions:

Drug	Age/year	Symptoms

Did you require emergency treatment for any of the above reactions? _____

Any history of venom (bee or wasp sting) allergy? _____

If so, please describe:

_____

_____

Any history of latex (gloves, condoms, balloons, etc.) allergy? _____

If so, please describe:

_____

_____

INFECTION HISTORY:

Please note how many times you have had the following infections:

Pneumonia		**Bronchiolitis/RSV infection**	
Bronchitis		**Sinusitis/Sinus infection**	
Croup		**Ear infection**	
Strep throat/Pharyngitis		**Influenza**	
Varicella/Chicken pox		**Zoster/Shingles**	
Cellulitis		**Abscess/Boil**	
Fungal skin infection		**Fungal nail infection**	

Have you ever had to be hospitalized for IV antibiotics? _____

Riverview Health Physicians Allergy & Immunology
17600 Shamrock Blvd, Suite 500A,
Westfield, IN 46074
T 317.214.5725

FAMILY HISTORY:

Have any family members had any of the following (please state which family member):

Asthma: _____ **Environmental allergies:** _____

Eczema: _____ **Chronic hives:** _____

Thyroid disease: _____ **Rheumatoid arthritis:** _____

Lupus: _____ **Other autoimmune:** _____

Leukemia/lymphoma: _____ **Immune deficiency:** _____

SOCIAL HISTORY:

Occupation: _____

Where do you live (circle)? House Apartment Mobile home Other: _____

How long have you lived there? _____

What kind of A/C (circle)? Central Window units Other: _____

What kind of heating? Central Baseboard Radiator Fireplace Other: _____

Is your basement (circle): Finished Unfinished Dry Damp None

Does your bedroom have (circle): Carpet Hard floor Window blinds Stuffed animals
Dust mite covers on pillows/mattress

Do you have any pets? Dog Cat Bird Rodent Reptile Other: _____

Have you ever smoked or used tobacco or similar products?

Current user Former user Never

If previously, how long ago did you quit? _____

If yes, please circle: Cigarettes Cigars Chewing Vaping

HEALTHCARE MAINTENANCE:

Are there any vaccines you are due for that you haven't received?

_____

Did you get a flu shot last/this flu season? _____