NORTH TEXAS ASTHMA & ALLERGY CENTER
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NEW PATIENT QUESTIONNAIRE

Appointment date and time:____

Patient Name:_______________________________Date of Birth________________

Primary Care Physician:____

Who Referred You?____

What problem(s) led you to seek this evaluation?_______________________________

PLEASE CIRCLE ALL ANSWERS THAT APPLY:

Do you live in a: House Condo Apartment

How old is the residence?____

Are there smokers in the residence? Yes No

Do you smoke or have a history of smoking? Yes No

If yes, how many years have you smoked?____________________________________

If you are no longer smoking, when did you quit?_______________________years ago

Are there pets in the residence? Yes No Dogs(#)_____ Cats (#)_____

Are the animals: Inside Outside Both

Are you exposed to strong odors or mold? Yes No

What is your current occupation?____

Were you a full term birth? Yes No

Do you change the air filters in your residence? Yes No

TELL US ABOUT YOUR MEDICAL HISTORY:

Please list any serious illnesses:____

Have you been hospitalized? Yes No

If yes, when and where were you hospitalized?____________________________________

____

Have you required surgery? Yes No

If yes, when and why was the surgery required?___________________________________

____

TELL US ABOUT YOUR FAMILY:

Does anyone in your family have a history of:

Allergies(**A**) Asthma(**AS**) Sinus Disease(**S**) Hives(**H**)

Please enter one or more of the above letters in the spaces indicated

Mother__________ Father__________ Brother__________ Sister__________

Grandmother (Maternal)__________ Grandfather (Maternal)__________

Grandmother (Paternal)__________ Grandfather (Paternal)__________

Other__________

Are any of your family members currently patients of Dr. Moore's? Yes No

If yes, who?____

ADDITIONAL MEDICAL INFORMATION:

Have you seen an allergist in the past? Yes No

If yes, who?______________________________________When?_________________

Were you allergy tested? Yes No

If yes, what did you test positive to?____

ADDITIONAL MEDICAL INFORMATION CONT'D:

Were you on allergy shots? Yes No

If yes, how long?__________________ Did the allergy shots help? Yes No

Are you currently on allergy shots? Yes No

If yes, when did you start (year)?____

Have you seen improvement in symptoms since starting shots?

None Moderate Significant

When do symptoms occur?

Seasonal (Fall Winter Spring Summer) Year round Both

What makes symptoms worse?

Animals Dogs Cats Changes in Barometric Pressure

Dust Emotions Exercise Grass Home

Indoors Infection Irritants Mold Outdoors

Rain Trees Weather Change Weeds

Workplace Wind

Do you have Lower Respiratory problems, Asthma, Reactive Airways or Wheezing? Yes No

How old were you when these problems started?____________________________________

Has Asthma been diagnosed? Yes No

What symptoms do you have?

Chest tightness Wheezing Shortness of breath Cough

Decreased exercise ability

When do symptoms occur?

Seasonal (Fall Winter Spring Summer) Year round Both

TELL US ABOUT YOUR PATTERNS:

How often are the attacks?____________ times per (week month year)

Do you have nighttime cough? Yes No

Do you miss school/work? __________ times per (week month year)

Have you had sudden severe attacks? Yes No

Urgent visits to the emergency room? Yes No

If yes, number of admissions____

What makes symptoms worse?

Animals	Aspirin	Cat	Changes in weather
Cold Air	Dogs	Dust	Eating
Emotions	Exercise	Foods	Grasses
Home	Indoors	Infections	Irritants
Laughter	Laying Down		Menstruation
Molds	Outdoors	Rain	Smoke
Weeds	Workplace		

MEDICATIONS:

Do you have allergies to any medications, foods or insects? (Please be specific)___________

____

What allergy medications are you currently taking?

Antihistamines____

Nasal Sprays____

Other____

MEDICATIONS CONT'D

What asthma medication are you currently taking?___________________________________

Rescue medication:

Albuterol Maxair Xopenex Foradil Ventolin Proventil

Controller Medication:

Advair:	100/50 mcg	250/50 mcg	500/50 mcg
Pulmicort:	Respules 0.25 mg	Respules 0.5 mg	Turbuhaler
Flovent:	44mcg	110mcg	220 mcg
Singulair:	4mg	5mg	10mg
Asmanex	220mcg		

Please list any other prescription medications?_____________________________________

____

REVIEW OF SYSTEMS:

Please circle all of the choices that you now or have ever had as recurring or serious problems:

Constitutional:	Fatigue	Tired	Fever
Respiratory:	Shortness of breath	Wheeze	Cough
	Trouble with exercise	Tight chest	Cough at night
	Short of breath with exercise		Hard getting air in
	Nighttime cough/shortness of breath		
Gastrointestinal:	Heartburn/indigestion	Reflux	Vomiting
	Diarrhea	Trouble swallowing	Abdominal pain
Genitourinary:	Frequent UTI's		

REVIEW OF SYSTEMS CONT'D

Allergy/Immunology:	Recurrent sinus infections	Recurrent ear infections	
	Recurrent throat infections	Recurrent pneumonia	
	Recurrent bronchitis	Recurrent skin infections	
	Itching eyes or nose	Hives	Swelling
Musculoskeletal:	Stiff/sore joints	Muscle pain	Red swollen joints
Eyes:	Blurry vision	Itch	Tearing
	Red eyes	Frequent infections	
Ear/Nose/Throat/Mouth:	Runny nose	Stuffy nose	Itchy nose
	Sneeze	Loss of smell	Post nasal drip
	Snore	Sore throat	Popping
	Drainage	Frequent infections	Itchy mouth
	Sinus congestion	Hoarseness	Ringing
	Bloody nose		
Cardiac:	Chest pain	Increased heart rate	Chest tightness
Neurologic:	Seizures	Headaches	Dizziness
Skin:	Dryness	Itch	Sores
	Red	Hives	Swelling
	Rash	Frequent infections	

REVIEW OF SYSTEMS CONT'D

<u>Heme/Lymph:</u>	Unusual bleeding	Unusual bruising	Swollen lymph nodes
<u>Endocrine:</u>	Weight gain	Heat intolerance	Constipation
	Cold intolerance	Weight loss	
<u>Psych:</u>	Anxiety	Depressed	Stressed
	Worried		

Signature of person completing this form____