FERRELL-DUNCAN CLINIC
ALLERGY / IMMUNOLOGY
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Name: _____
First Middle Last

Age: _____ Height: _____

Date of Birth: _____ Weight: _____

Address: _____ Telephone: Home: _____

_____ Work: _____

Were you referred by a physician? _____ Yes _____ No

If yes, please provide us with the name, address and phone number of the physician referring you:

_____

_____

_____

Who is your primary care physician? (Name, address and phone number)

Would you like us to send a letter to your primary care physician regarding your visit with us? _____ Yes _____ No

_____

_____

If there are other physicians whom you wish to receive copies of our evaluation, please list the

names, addresses and phone numbers of these physicians below:

_____

_____

The following new patient questionnaire is detailed. Please take the time to fill it out before your visit to help you recall important features of your condition and help our doctors diagnose and treat you. Thank you!

Physician Signature: **Date:**

ALLERGY / IMMUNOLOGY HISTORY

Please describe in your own words the primary medical problem and duration of symptoms which has caused you to seek an evaluation _____

_____

_____

When did your symptoms start: _____

Circle the symptomatic months: Jan Feb Mar Apr May Jun Jul Sep Oct Nov Dec All year round
Spring Summer Fall Winter

REVIEW OF SYSTEMS

Head: ☐headaches : quality - ☐dull ☐throbbing ☐pressure, frequency of headaches :_____
☐headache location - ☐forehead ☐cheeks ☐behind the eyes ☐temples ☐back of the head
☐band-like

Eyes: ☐itching ☐burning ☐redness ☐watering ☐swelling ☐shiners (dark circles under eyes)
☐dryness ☐discharge ☐visual problems_____

Ears: ☐itching ☐pain ☐infections ☐tubes: years_____☐popping ☐hearing loss ☐fullness

Nose: ☐itching ☐sneezing ☐congestion (worse in the ☐AM ☐PM ☐all day) ☐drainage (color:
☐post-nasal drip ☐snoring ☐runniness ☐blood ☐decreased smell

Throat: ☐soreness ☐redness ☐itching ☐mucus ☐throat clearing ☐hoarseness ☐bad breath☐swelling

Resp: ☐wheezing ☐chest tightness ☐shortness of breath at rest ☐shortness of breath with exertion
☐ snoring ☐cough (worse in the ☐AM ☐PM ☐all day) Cough triggers: ☐ laughter ☐ lying down
☐night time awakening from cough/wheezing: # _____ ☐ ER visits in past year, #_____
☐ hospitalizations for respiratory problems, #_____ ☐ Prednisone in past year, # _____

Skin: ☐eczema ☐rash ☐hives ☐swelling ☐itching ☐dry skin

Imm: ☐facial rash ☐mouth ulcers ☐nose ulcers ☐easy bruising ☐sun sensitivity ☐cold sensitivity
☐joint swelling/pain☐recurrent infections (☐ear ☐sinus ☐throat ☐chest ☐skin ☐urinary tract)
☐how many infections in the last year_____ ☐how many courses of antibiotics in the last year_____

CV: ☐ chest pain ☐ palpitations (feeling heart beat) ☐ tachycardia (fast heart rate) ☐ leg swelling

GI: ☐heartburn/reflux (worse in the ☐AM ☐PM ☐after meals ☐all day ☐makes the cough worse)
☐hiatal hernia ☐nausea ☐vomiting ☐diarrhea ☐constipation ☐pain__

MS: ☐joint pain ☐joint swelling ☐muscle pains ☐muscle weakness ☐muscle wasting ☐leg swelling

Endo: ☐weight gain ☐weight loss ☐amount of weight change_____in how long _____
☐hot flashes ☐fever ☐ night sweats ☐hair loss ☐hot flashes ☐hair loss ☐goiter ☐miscarriages
☐irregular menses ☐post-menopausal ☐nursing ☐pregnancy ☐planning pregnancy, when _____

GU: ☐blood in the urine ☐painful urination ☐incontinence ☐increased urination ☐nighttime urination

Psych/Neuro/Behavioral: ☐depression ☐anxiety ☐ irritability ☐ inability to concentrate ☐seizures
☐ memory problems ☐ fainting ☐vertigo ☐ problems at work or school ☐developmental delays

Physician Signature: **Date:**

Triggers:

Eye/Nasal symptoms worsened by:

☐smoke ☐aerosols ☐dust ☐perfumes ☐basements ☐cats ☐dogs

☐cold air ☐wind ☐beer/wine ☐temperature changes ☐humidity ☐rain ☐season changes

☐heartburn/reflux ☐others _____

Lung symptoms are worsened by:

☐smoke ☐aerosols ☐dust ☐perfumes ☐basements ☐cats ☐dogs

☐cold air ☐wind ☐beer/wine ☐temperature changes ☐humidity ☐rain ☐season changes

☐activity ☐respiratory infections ☐laughing ☐aspirin products ☐heartburn

☐others_____

Skin History (Hives and/or rash and/or swelling/angioedema: skip if no skin problems):

Skin: ☐eczema ☐rash ☐hives ☐swelling ☐itching ☐dry skin_____

Features: Date of onset: _____ Worse in: ☐AM ☐PM ☐after meals ☐all day

Affected areas: ☐hands ☐arms ☐feet ☐legs ☐stomach ☐back ☐head/face

Appearance: ☐red ☐flat ☐raised ☐blistery ☐leaves marks/bruises

☐hives/rash moves around ☐hives stay in one spot ☐how long does the rash or hives last for?

Skin Triggers: ☐heat ☐exercise ☐sunlight ☐cold ☐water ☐pressure ☐vibration ☐rubbing/scratching

☐menstrual cycle ☐stress ☐foods _____

☐poison ivy/oak/sumac ☐cut grass ☐leaves ☐plants ☐cosmetics ☐soaps ☐wool

☐others_____

Skin products: Soap: _____ Shampoo: _____ Conditioner: _____

Detergent: _____ Fabric softener: _____

Toothpaste: _____ Cosmetics: _____

Perfumes: _____ ☐Any recent changes, _____

Prior Allergy/Immunology evaluation:

☐ Allergy testing, year____ ☐ Sinus x-ray or CT, year _____ ☐ Lung CT, year _____ ☐ Chest XRAYs, year___

☐ Immunological tests , year _____ ☐ Previous Allergy injections , year(s)_____

Stings: ☐insect reactions to: ☐bees ☐wasps ☐hornets ☐fire ants ☐mosquitoes ☐chiggers

☐reaction: ☐large local reactions ☐hives ☐wheezing ☐throat swelling ☐nausea/diarrhea

☐unconsciousness ☐emergency treatment age at time of reaction_____

☐other history of anaphylaxis, age at time of reaction _____

Tick Bites/Exposure: ☐ Yes ☐ No When last bite occurred_____

Physician Signature: **Date:**

Environmental History:

Home: ☐Townhouse ☐Apartment ☐House (age_____yrs, occupied for_____ yrs)

☐City/suburban ☐Rural/Farm

Basement is: ☐dry ☐damp ☐musty ☐finished ☐dehumidifier in use ☐Crawlspace ☐Slab home

☐ water damage in home ☐ visible mold in home

Windows are open during: ☐Spring ☐Summer ☐Fall ☐Winter ☐never

Attic fan is used in the: ☐Spring ☐Summer ☐Fall ☐Winter ☐never

Heating is: ☐natural gas ☐electric ☐wood ☐other _____

Humidifier is: ☐attached to the furnace ☐free standing (location _____)

Air conditioning is: ☐central ☐window unit ☐no air conditioning

Air filter is: ☐disposable (how often is it changed?_____) ☐HEPA filter ☐electronic ☐electrostatic

Bedroom: Location - ☐above ground ☐in the basement Flooring - ☐carpeting ☐hardwood ☐area rug

Pillow: ☐feather ☐synthetic ☐new ☐old (how old?_____) ☐dust proof/allergy cover

Mattress: ☐standard ☐waterbed ☐new ☐old (how old? _____) ☐dust proof/allergy cover

Bedding: washed ☐weekly ☐monthly ☐in hot water ☐in warm water ☐in cold water

Pets: ☐Cats (number _____☐indoor ☐outdoor) ☐Dogs (number _____☐indoor ☐outdoor)

☐Birds ☐Rabbits ☐Guinea pigs/Hamsters ☐Horses ☐Other_____

Where do your pets sleep?_____ Do they have access to your bedroom? _____

MEDICATIONS

Please list all the medications that you are now taking.

Medication Name	Dose	Frequency	Time last taken

Physician Signature: **Date:**

Previous Allergy-type medications you have taken

Medication Name	Effective	Not effective	Time last taken

MEDICATION/FOOD/OTHER ALLERGIES:

Have you ever had an adverse/allergic reaction to a medication, food, chemical, or other product? ☐ Yes ☐ No

If yes, please describe to what drug(s)/food(s)/other product(s), approximate year of the incident(s) and type of reaction(s)

Medication/Food/Product Name	Year	Type of reaction

Past Medical History:

Immunizations: ☐Tetanus/DPT, year _____ ☐Seasonal flu, year _____ ☐Pneumonia, year _____

☐Up to date on childhood vaccinations

☐Reactions to immunizations, describe _____

Major Illnesses/Diagnoses: _____

_____

_____

_____

Physician Signature: **Date:**

Surgical History: _____

_____

_____

Social History

☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated

☐ Occupation: _____ ☐ Retired ☐ Disabled, reason_____

☐ Prior occupations:_____

☐ Hobbies/crafts:_____

Alcohol use: ☐ None ☐ Rare/Occasionally ☐ Weekly, # per week____

☐ Daily, # of per day ___

Tobacco use: ☐ Cigarettes, packs per day_____, for how many years_____

☐ When did you quit? _____ ☐ Smokers in the home

☐ Smokeless tobacco ☐ Cigars

Illicit drug use: ☐ Past, type_____ ☐ Current, type_____

Family History

Does anyone in your family (grandparents, aunts, uncles, cousins, parents, siblings, children) have any of the following illnesses? If yes, tell us who has the illness.

Seasonal allergies	☐ Yes	☐ No	_____
Food allergies	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Eczema	☐ Yes	☐ No	_____
Cancer	☐ Yes	☐ No	_____
Heart Disease	☐ Yes	☐ No	_____
Diabetes	☐ Yes	☐ No	_____
Hives	☐ Yes	☐ No	_____
Angioedema	☐ Yes	☐ No	_____
Autoimmune dz	☐ Yes	☐ No	_____
Thyroid disease	☐ Yes	☐ No	_____
Cystic Fibrosis	☐ Yes	☐ No	_____
Other (Please explain):	☐ Yes	☐ No	_____

Please use this blank space for anything else you think is important or would like us to address at your visit:

Physician Signature: **Date:**