CoxHealth Allergy & Immunology
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Name: _____ _____ _____
First Middle Last

Age: _____ Height: _____ Weight: _____

Date of Birth: _____ Home Phone: _____

Address: _____ Cell Phone: _____

_____ Work Phone: _____

Were you referred by a physician/health care provider? □ Yes □ No
If Yes, please provide us with the name, address, and phone number of the physician referring you:

_____

_____

_____

Would you like us to send a letter to your primary care provider regarding your visit with us? □ Yes □ No
If Yes, please provide us with the name, address, and phone number of your primary care provider:
□ Same as referring provider

_____

_____

_____

If there are other providers whom you wish to receive copies of our evaluation, please list the names, addresses, and phone numbers here:

_____

_____

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 providers diagnose and treat you. Thank you!

_____ _____
Allergy Physician/NP Signature Date

Current Medications:

Medication name	Dose	Frequency	Last taken when?

Previous Allergy/Asthma Medications You Have Taken:

Medication name	Did it help?	Last taken when?
	□ No □ Yes	
	□ No □ Yes	
	□ No □ Yes	
	□ No □ Yes	

Medication/Food/Other Allergies:

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

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

Medication/food/product name	Year	Type of reaction

Past Medical History:

Major Diagnoses/Illnesses: _____

_____

_____

_____

_____

_____

Surgical History: _____

_____

_____

_____

Immunizations: Year of last Tetanus shot: _____ Year of last seasonal flu shot: _____

Year of last pneumonia shot: _____

Up to date on childhood immunizations: □ Yes □ No

Describe any reactions to immunizations: _____

REVIEW OF SYSTEMS

General:	□ Chills	□ Malaise (general feeling of illness)	
	□ Decreased appetite	□ Sweating	
	□ Fatigue	□ Weight gain	
	□ Fever	□ Weight loss	
Eye:	□ Blurred vision	□ Photophobia (light sensitivity)	
	□ Double vision	□ Redness	
	□ Drainage	□ Tearing/watering	
	□ Itching	□ Vision loss	
	□ Pain	□ Visual changes	
ENT:	□ Decreased hearing	□ Loss of smell	□ Swollen glands
	□ Dental pain	□ Nasal congestion	□ Tinnitus (ringing in the ears)
	□ Ear drainage	□ Postnasal drip	
	□ Ear pain	□ Rhinorrhea (runny nose)	
	□ Frequent nosebleeds	□ Sinus pressure	
	□ Hoarseness	□ Sore throat	
Cardiovascular:	□ Chest pain	□ Fainting	
	□ Shortness of breath with exertion	□ Palpitations (heart racing/skipping beats)	
	□ Edema (leg swelling)		
Respiratory:	□ Cough	□ Snoring	
	□ Shortness of breath at rest	□ Wheezing	
GI:	□ Constipation	□ Diarrhea	□ Nausea
		□ Heartburn	□ Vomiting
GU:	□ Blood in the urine	□ Painful urination	□ Incontinence
	□ Frequent urination	□ Night time urination	
MS:	□ Joint pain	□ Muscle pain	□ Muscle weakness
	□ Joint swelling		
Skin:	□ Pruritis (itching)	□ Rash	
Neuro:	□ Memory problems	□ Seizures	□ Vertigo (dizziness)
Psych:	□ Anxious mood	□ Depressed mood	□ Poor attention span
Endocrine:	□ Change in hair texture	□ Temperature intolerance	
Heme/Lymph:	□ Abnormal bruising		
Allergy/Imm:	□ Frequent infections	□ Hives	□ Seasonal allergies

FAMILY HISTORY

	Mother	Father	Sister	Brother	Maternal Grand Mother	Maternal Grand Father	Paternal Grand Mother	Paternal Grand Father	Other Family Member (list relationship)
Angioedema (lip swelling)	□	□	□	□	□	□	□	□	_____
Asthma	□	□	□	□	□	□	□	□	_____
Autoimmune disease	□	□	□	□	□	□	□	□	_____
Cancer	□	□	□	□	□	□	□	□	_____
Cystic Fibrosis	□	□	□	□	□	□	□	□	_____
Diabetes	□	□	□	□	□	□	□	□	_____
Eczema	□	□	□	□	□	□	□	□	_____
Emphysema	□	□	□	□	□	□	□	□	_____
Food allergies	□	□	□	□	□	□	□	□	_____
Heart disease	□	□	□	□	□	□	□	□	_____
Hives	□	□	□	□	□	□	□	□	_____
Seasonal allergies	□	□	□	□	□	□	□	□	_____
Thyroid disease	□	□	□	□	□	□	□	□	_____

SOCIAL HISTORY

Tobacco Use: □ Current smoker – every day
□ Current smoker – some days
□ Former smoker
□ Quit less than 30 days ago
□ Quit more than 30 days ago
□ Never smoked

Number of years used: _____
Stopped at age: _____

Type:
□ Chewing tobacco
□ Cigarettes
□ Cigars
□ Pipe
□ E-cigs/Vaping/Juul
□ Other _____

Tobacco Use Per Day:
□ <=4 cigarettes/day
□ 5-9 cigarettes/day
□ 10+ cigarettes/day
□ 1 pack per day
□ 1 1/2 packs per day
□ 2 packs per day
□ 3 packs per day
□ Other _____

Are there smokers in the patient's home? □ Yes □ No

Alcohol: □ None □ Past □ Current (indicate frequency): _____

Substance Use: □ None □ Past □ Current (indicate type & frequency): _____

Home: Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated
Lives with: □ Alone □ Children □ Father □ Mother
□ Siblings □ Significant Other □ Spouse □ Other _____
Hobbies: _____

Employment/School: □ Full time □ Part time □ Student □ Retired □ Unemployed
□ Disability □ Homemaker □ Other _____
Occupation: _____

Allergens: Days of work/school missed yearly on average due to respiratory symptoms: _____

Air Conditioning:
□ Central
□ Makes symptoms better
□ Window unit
□ None
□ Other: _____

Air Filter:
□ Disposable
□ Electronic
□ Electrostatic
□ HEPA filter
□ Other: _____

Basement:
□ Damp
□ Dry
□ Dehumidifier in use
□ Finished
□ Musty
□ N/A (crawlspace)
□ N/A (slab home)
□ Other: _____

Bedding:
□ Washed in cold water
□ Washed in hot water
□ Washed weekly
□ Washed monthly
□ Other: _____

Bedroom Curtains:
□ Blinds
□ Cloth curtains
□ Shades
□ Other: _____

Bedroom Flooring:
□ Area rug
□ Carpet
□ Hardwood
□ Linoleum
□ Tile
□ Other: _____
□ Other: _____

Bedroom Location: □ Above ground □ In basement

Cat:
□ Indoor
□ Outdoor
□ At daycare
□ None
□ Cat(s) sleep in bed

Dog:
□ Indoor
□ Outdoor
□ At daycare
□ None
□ Dog(s) sleep in bed

Home Heat Source:
□ Electric
□ Natural gas
□ Propane
□ Wood
□ Other: _____

Home Type:
□ Apartment
□ City/suburban
□ House
□ Townhouse
□ Rural/farm
□ Other: _____

Housedust Precautions:
□ Implemented
□ Partially implemented
□ Not implemented

Humidifier:
□ Attached to furnace
□Free standing
□ None

Main Flooring:
□ Area rug
□ Carpet
□ Hardwood
□ Linoleum
□ Tile
□ Other: _____

Mattress:
□ Dust proof/allergy cover
□ New
□ Old
□ Standard
□ Waterbed
□ Other: _____

Other Pets:
□ Birds
□ Guinea pigs/hamsters
□ Horses
□ Rabbits
□ Other: _____

Pillow:
□ Dust proof/allergy cover
□ Feather
□ New
□ Old
□ Synthetic
□ Other: _____

Wood Stove Exposure:
□ Yes
□ No

Daycare:
□ Yes
□ No

Exposure to Other Agents:
□ Asbestos/Silica
□ Chemicals
□ Industrial Agents
□ Radiation Treatments
□ Other: _____

ALLERGY/IMMUNOLOGY HISTORY

Please describe in your own words the primary medical problem and duration of symptoms that brought you to our office:

_____

_____

When did your symptoms start? _____

Mark the symptomatic months: □ Jan □ Feb □ Mar □ Apr □ May □ June □ Jul □ Aug □ Sep □ Oct □ Nov □ Dec

□ Spring □ Summer □ Fall □ Winter □ All year round

Triggers:

Eye/nasal symptoms worsened by:

□ smoke □ aerosols □ dust □ perfumes □ basements □ cats □ dogs

□ cold air □ wind □ beer/wine □ temp changes □ humidity □ rain □ season changes

□ heartburn □ other: _____

Lung symptoms worsened by:

□ smoke □ aerosols □ dust □ perfumes □ basements □ cats □ dogs

□ cold air □ wind □ beer/wine □ temp changes □ humidity □ rain □ season changes

□ activity □ resp infection □ laughing □ heartburn □ aspirin products

□ other: _____

Skin symptoms worsened by:

□ heat □ exercise □ sunlight □ cold □ vibration □ water □ vibration

□ rubbing □ scratching □ wool □ cut grass □ leaves □ plants □ poison ivy/oak

□ soaps □ cosmetics □ menstrual cycle □ foods: _____

□ other: _____

Skin history: (hives, rash, swelling, angioedema: skip if no skin problems):

Skin problems: □ 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

□ moves around □ stays in one spot how long does it last? _____

Current Skin: soap: _____ shampoo: _____ conditioner: _____

Products detergent: _____ fabric softener: _____

toothpaste: _____ cosmetics: _____

perfumes: _____ any scent changes? _____

Stings: reactions to: □ bees reaction type: □ large local reactions

□ wasps □ hives □ wheezing

□ hornets □ throat swelling □ nausea/diarrhea

□ fire ants □ unconsciousness

□ mosquitoes □ required emergency treatment

□ chiggers age at time of first reaction: _____

Tick bites/exposure: □ No □ Yes When did last bite occur? _____

Anaphylaxis:

Other history of anaphylaxis? □ No □ Yes Age at time of reaction: _____ Trigger if known: _____