The Ohio State Wexner Medical Center Allergy/Immunology New Patient Questionnaire

Patient Name:________________________________ Date of Birth:_________________
Patient Address:_______________________________ Phone:______________________
Primary Care Doctor:___________________________ Address:__________________________________

Current Medications	Dose	How Often	Duration Taken

Past Medical History: (circle all that apply)	Cirrhosis	Heart attack	Stroke	Cancers
Asthma	Deafness	Heart murmur	Tuberculosis	Head/neck
Angina	Depression	High blood pressure	Thyroid disease	Lung
Anemia	Diabetes	Hepatitis		Breast
Arthritis	Emphysema	Hemorrhoids		Stomach
Bleeding problems	Glaucoma	Kidney stones	Males	Colon
Broken bones	Gallstones	Rheumatic fever	Prostate problems	Liver
Cataracts	Gout	Stroke	Females	Lymphoma
Chronic bronchitis	Goiter	Stomach ulcer	Menstrual problems	Leukemia

Past Surgical History:
Have you ever had sinus surgery? Yes/No If yes, when?_____________ If yes, who?___________
Please list any other surgeries you may have had (include approximate dates):____________________________
____

Family History:	Father	Mother	Siblings	Children	Grandparents	Others
Allergies						
Asthma						
Immune system problems						

Medication Allergies:- No known drug allergies □

Medication Name	Reaction	When did it occur

Social History:
Have you ever used tobacco? Yes/No Do you currently use tobacco? Yes/No What kind?________
How much per day/week?____________ How long?_________ When did you quit?________
Do you drink alcohol? Yes/No How many per week? Beer______ Wine______ Liquor_______

Vaccination History:
Did you receive your childhood vaccinations? Yes/No
Have you ever had bad reaction to a vaccine? Yes/No What happened? ______________________________
When was your last tetanus vaccine? ________________ Pneumonia vaccine? ___________________________

Infection History:	Yes/No	How many?		Yes/No	How many?
Pneumonia			Sepsis		
Ear infections			Skin infections/boils		
Sinus infections			Fungal/yeast		
Bronchitis			Severe warts		
Meningitis			Urinary tract/kidney		
Stomach/intestines			Other:		

What symptoms are bringing you in today?____
____
When did these symptoms begin?________________ How often are they affecting you?___________________
What makes your symptoms worse?____
What makes your symptoms better? ____
Is there anything else you want us to know before your visit?____
____

Medications you have tried for this problem in the past:	Did it work? (Y/N)	Side effects or problems?

Have you ever seen an allergist before? Yes/No When? _____________ Who?______
Have you ever been allergy tested before? Yes/No When? _____________
Have you been on allergy shots before? Yes/No When and how long?_________
Have you ever had an allergic reaction to food? Yes/No Which food?_______________
What happened?____
Have you have had a reaction to insect stings? Yes/No What insect?_______________
What happened?____
Have you ever had an anaphylactic reaction? Yes/No What happened?________________________

Review of Systems: Circle all that apply.
General: Chills, Fatigue, Fever, Weight gain, Weight loss
Skin: Dryness, Itching, Lesion, Rash
Ears, Nose, Throat: Sinus pain, Hearing loss, Nasal congestion, Nosebleeds, Hoarseness
Eyes: Blurred vision, Eye redness, Eye watering
Heart: Chest pain, Leg swelling, Palpitations
Lungs: Cough, Shortness of breath, Wheezing
Stomach/intestines: Abdominal pain, Heartburn, Trouble swallowing, Vomiting
Urinary: Pain with urination, Blood in urine, Incontinence
Muscles: Joint pain, Joint swelling, Muscle pain, Muscle weakness
Nerves: Dizziness, Headache, Seizures
Mood: Depression, Insomnia, Anxiety
Blood: Easy brusing/bleeding, Lymph node swelling
Endocrine: Hot flashes, Sweating
Allergy: Hives, Lip or tongue swelling

Environmental history:
What kind of home do you live in (house, apartment, etc.)__________________________________
Do you have a basement? Yes/No
Is there any mold/moisture/mildew in home? Yes/No Where?__________________
Do you have any pets in your home? Yes/No What?__________________________________
What type of flooring is in your bedroom (carpet, hardwood, etc.)? ______________________
Do you have dust mite covers on your mattress and pillows? Yes/No
Do you have down/feather pillows or comforters on your bed? Yes/No
Is anyone at home a smoker? Yes/No
Do you have central air conditioning? Yes/No Do you have a wood burning stove/heater? Yes/No
Occupation: _______________Are you exposed to chemicals/fumes at work? Yes/No What?_______________

For Sinus/Allergy patients ONLY

I.D.:________________ **SINO-NASAL OUTCOME TEST (SNOT-22)** DATE:________________

Below you will find a list of symptoms and social/emotional consequences of your rhinosinusitis. We would like to know more about these problems and would appreciate your answering the following questions to the best of your ability. There are no right or wrong answers, and only you can provide us with this information. Please rate your problems as they have been over the past two weeks. Thank you for your participation. Do not hesitate to ask for assistance if necessary.

1. Considering how severe the problem is when you experience it and how often it happens, please rate each item below on how "bad" it is by circling the number that corresponds with how you feel using this scale: →	No Problem	Very Mild Problem	Mild or slight Problem	Moderate Problem	Severe Problem	Problem as bad as it can be		5 Most Important Items
1. Need to blow nose	0	1	2	3	4	5		○
2. Nasal Blockage	0	1	2	3	4	5		○
3. Sneezing	0	1	2	3	4	5		○
4. Runny nose	0	1	2	3	4	5		○
5. Cough	0	1	2	3	4	5		○
6. Post-nasal discharge	0	1	2	3	4	5		○
7. Thick nasal discharge	0	1	2	3	4	5		○
8. Ear fullness	0	1	2	3	4	5		○
9. Dizziness	0	1	2	3	4	5		○
10. Ear pain	0	1	2	3	4	5		○
11. Facial pain/pressure	0	1	2	3	4	5		○
12. Decreased Sense of Smell/Taste	0	1	2	3	4	5		○
13. Difficulty falling asleep	0	1	2	3	4	5		○
14. Wake up at night	0	1	2	3	4	5		○
15. Lack of a good night's sleep	0	1	2	3	4	5		○
16. Wake up tired	0	1	2	3	4	5		○
17. Fatigue	0	1	2	3	4	5		○
18. Reduced productivity	0	1	2	3	4	5		○
19. Reduced concentration	0	1	2	3	4	5		○
20. Frustrated/restless/irritable	0	1	2	3	4	5		○
21. Sad	0	1	2	3	4	5		○
22. Embarrassed	0	1	2	3	4	5		○

2. Please mark the most important items affecting your health (maximum of 5 items)________________ ↑

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