Rady Children's Hospital - San Diego
3020 Children's Way
San Diego, CA. 92123

Allergy & Asthma Medical Group

DTF1372

PATIENT INFORMATION

Name: _____
MR#: _____ Finance: _____
DOB: _____
MD: _____

Patient Allergy History Questionnaire – Adult

Patient's Name _____ Date of Birth ____/____/_____

Date form completed: _____ RCHSD patient number: _____

What is the main reason you are being seen in the Allergy Immunology Clinic?

_____

_____

_____

Please answer the following questions to help us learn more about you:

1. COUGH OR POSSIBLE ASTHMA (if none go to section 2)
Check any of the following that are problems for you:

☐ cough ☐ wheeze ☐ shortness of breath ☐ chest tightness

How old were you when you first began having these chest symptoms? _____

Are there a certain times of year when these asthma/chest symptoms are worse? ☐Yes ☐No
If yes, which months? _____

Check any of the following that make the asthma/chest symptoms worse: ☐ animals, which animals: _____

☐ dust ☐ grass ☐ smoke ☐ fumes/strong smells ☐ cold air ☐ windy weather

☐ respiratory infections ("colds") ☐ exercise ☐ other (list) _____

Have you ever had to stay overnight in the hospital because of asthma/chest symptoms? ☐ Yes ☐ No
If yes, approximately how many times: _____ Date of last hospital stay: _____

Have you ever needed to be in the intensive care unit (ICU) for asthma? ☐Yes ☐No How many ICU stays?: _____

Have you ever needed to be intubated (a tube in your throat used to help you breath) for your asthma? ☐Yes ☐No

If Yes, give details: _____

Have you ever had to go to the emergency room or urgent care because of asthma/chest symptoms? ☐ Yes ☐ No
If yes, how many times in the past 12 months _____

How many times have you been treated with oral steroids (e.g. prednisone, dexamethasone, Decadron, Medrol) in the last year? _____

Have you had "bronchitis"? ☐ Yes ☐ No How often in the last few years? _____

Have you ever had "pneumonia"? ☐ Yes ☐ No If yes, how many episodes? _____
How many days of work have you missed due to your symptoms? _____ What type of work? _____
How often do you have daytime cough or wheeze problems? ☐ every day ☐ often ☐ sometimes ☐ rare
Do you cough at night while sleeping? ☐ Yes ☐ No If yes, how often? ☐every night ☐ often ☐ sometimes
How many nights have you awakened from sleep because of asthma, or symptoms of wheezing or cough in the last 4 weeks? _____
How many days or nights in the past 2 weeks have you needed to use an inhaler or nebulizer to treat wheezing or cough? _____
Do you have a peak flow meter: ☐ Yes ☐ No If Yes, best peak flow reading: _____

Do you have an Asthma Action Plan? ☐ Yes ☐ No

Which of the following medications have been used for your asthma or chest symptoms?

☐ albuterol (e.g. Proventil, Proair, Ventolin, Xopenex)

☐ oral steroids (e.g. prednisone, prednisolone, Prelone, dexamethasone, Decadron, Medrol)

☐ montelukast (Singulair)

☐ inhaled steroids (e.g. QVar, Flovent, Alvesco, Asmanex, Pulmicort, Aerospan)

☐ inhaled steroids and long acting beta agonist (e.g. Advair, Symbicort, Dulera)

☐ ipratropium (e.g. Atrovent) ☐ ipratropium and albuterol (e.g. Combivent)

☐ nebulized medications (e.g. albuterol, Proventil, Ventolin, Xopenex, ipratroprium, Atrovent, Duoneb, budesonide, Pulmicort)

☐ don't remember

2. NOSE OR EYE SYMPTOMS (If none go to Section 3)

Check any of the following that are problems for you: ☐ runny nose ☐ stuffy nose ☐ itchy nose ☐ sneezing fits ☐ nose blowing ☐ watery eyes ☐ red eyes ☐ itchy eyes ☐ itchy ears ☐ itchy throat ☐ post nasal drip ☐ throat clearing

How old were you when these nose/eye symptoms first began? _____

In which seasons do these nose/eye symptoms occur? ☐ Spring (March to May) ☐ Summer (June to August) ☐ Fall (September to November) ☐ Winter (December to February) ☐ All the time ☐ Variable, no pattern

Check any of the following that make nose/eye symptoms worse: ☐ cats ☐ dogs ☐ dust ☐ grass ☐ smoke ☐ fumes ☐ cold air ☐ other: _____

Have you ever had allergy skin testing before? ☐ No ☐ Yes

If yes, check those tests that were positive: ☐ dust Mite ☐ pollen ☐ mold ☐ animal hair ☐ foods ☐ don't remember

Which of the following medications have been used for your symptoms ?

☐ oral antihistamine (e.g. loratadine, Claritin, cetirizine, Zyrtec, fexofenadine, Allegra, diphenhydramine, Benadryl, other OTC ones)

☐ oral decongestants (e.g. pseudoephedrine, Sudafed)

☐ nasal steroid (e.g. fluticasone, Flonase, mometasone, Nasonex,, mometasone furoate, Veramyst, budesonide, Rhinocort, triamcinolone, Nasocort

☐ antihistamine nose spray (e.g. Patanase, Astelin, Astepro) ☐ combination antihistamine/steroid nose spray (Dymista)

☐ nasal spray decongestant (e.g oxymetazoline, Afrin, neosynephrine) ☐ nasal saline

☐ OTC meds: _____

☐ don't remember

Have you ever been on allergy shots before? ☐ Yes ☐ No If yes, when? _____

Are you interested in discussing allergy injections with the doctor today? ☐ Yes ☐ No

3. SINUS INFECTIONS, EAR INFECTIONS (if none, go to section 4)

Have you had frequent ear infections? ☐ Yes ☐ No If yes, how many in the last year? _____

Have you had frequent sinus infections? ☐ Yes ☐ No If yes, how many in the last year? _____

At what age did the ear or sinus infections start? _____

How many times have antibiotics been needed in the last year for either sinus or ear infections? _____

Do you respond well to antibiotic therapy, when used? ☐ Yes ☐ No

Have you needed to see the ear/nose/throat (ENT) doctor? ☐ Yes ☐ No If yes, when? _____

Have any tests (e.g Xrays, blood work) been done for your ear and/or sinus infections? ☐ Yes ☐ No If yes, what tests?

_____

Has ENT surgery been needed? ☐ Yes ☐ No If yes, what type, and when? _____

4. ECZEMA (CHRONIC DRY ITCHY SKIN) (if none go to section 5)

How old were you when you first began having eczema? _____

Check body parts with eczema: ☐ face ☐ neck ☐ scalp ☐ arms ☐ elbows ☐ wrists ☐ fingers ☐ legs ☐ knees ☐ ankles ☐ feet ☐ chest ☐ abdomen ☐ back

What seems to trigger the eczema? _____

Are there any foods that seem to worsen the eczema? ☐ Yes ☐ No If yes, which foods? _____

Check off skin medication preparation you have used:

☐hydrocortisone ☐Aclovate ☐triamcinolone ☐Cutivate ☐Elocon ☐other topical steroids: _____

☐Elidel ☐Protopic ☐ don't remember ☐other: _____

Do you use a regular skin moisturizer? If Yes, which one? _____

5. FOOD ALERGY REACTIONS (if none go to section 6) - List foods to which you suspect you are allergic and check reaction type

Food	Itchy mouth, throat	Rash/hives/ eczema	Vomiting/ diarrhea	Facial Swelling	Wheezing, coughing	Difficulty breathing	Shock	Other

How long after eating the food did the reaction occur (check one): ☐ within 2 hours ☐ 2·24 hours ☐ greater than 24 hours

Did you go to the emergency room or acute care for the reaction? ☐ Yes ☐ No

Did you require oral medicine or a shot to treat the reaction? ☐ Yes ☐ No

How old were you when you/he/she had the first suspected reaction to the food? _____

When was your most recent reaction to the food? _____

Have you ever had skin tests or blood tests for food allergy? ☐Yes ☐No
If yes, which tests were positive? _____
Do you have a self-injecting epinephrine device, like EpiPen or Auvi Q? ☐Yes Which one? _____ ☐No

6. HIVES (if none, go to section 7)

Do you get hives? ☐ Yes ☐ No
If yes, how often? ☐ daily ☐ frequent ☐ often ☐ occasional ☐ rare
Where do the hives occur on the body? ☐ everywhere ☐ face mainly ☐ lips mainly ☐ trunk, abdomen mainly ☐ extremities mainly ☐ feet mainly ☐ hands mainly
Is there a trigger for the hives? ☐ food ☐getting hot ☐ cold exposure ☐ pressure ☐ other: _____
Do the hives get better with using an antihistamine (e.g. Benadryl, Claritin, Zyrtec, Allegra)? ☐ Yes ☐ No
Have any tests been done to evaluate the hives? ☐ Yes ☐ No If yes, what tests, and what were the results?

_____

7. INSECT REACTIONS (if none, go to section 8)

Have you had a bad reaction (e.g. hives, wheezing, swelling, paleness, etc.) to a sting by a:

☐ bee? ☐ wasp? ☐yellow jacket? ☐ hornet? ☐ ant? ☐ other: _____

Describe the reaction: _____

When was the latest reaction? _____

Have you been prescribed an epinephrine autoinjector, like EpiPen or AuviQ? ☐ Yes ☐ No

Do you get large local swelling reactions to stinging insects? ☐ Yes ☐ No If yes, describe what happens:

_____

8. MEDICATION ALLERGIES, AND OTHER TYPES OF ALLERGIES

Are you considered allergic to any antibiotics, or other medication? ☐ Yes ☐ No

If yes, give details of what happened

- which medication? _____
- what kind of a reaction? _____

Are you allergic to latex (balloons, rubber, or elastic) ☐ Yes ☐ No

If yes, give details of what happened: _____

Do you have any contact allergies ☐ Yes ☐ No

If yes, give details: _____

MEDICATIONS

List all medicines you are currently taking for any reason (include prescription, over the counter, herbal, homeopathic)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

ENVIRONMENT

Check any pets you have: ☐ Dogs Indoors and/or outdoors ?(circle)

☐ Cats Indoors and/or outdoors? (circle)

☐ Hamster ☐ Guinea Pig ☐ Other: _____

Do any members of your household smoke: ☐ Yes ☐ No

About how old is your home? _____ years

Has there been any water damage or mold present in the home? ☐ Yes ☐ No

What kind of flooring is in the bedroom? ☐ Carpet ☐ Tile ☐ Wood

FAMILY HISTORY (**Check all that apply):**

Relative	Asthma	Hay fever, nasal allergy	Eczema	Food allergy	Hives	Reflux/Heartburn
Mother						
Father						
Brother or Sister						
Aunts, uncles						

List other diseases that run in the family: _____

PAST MEDICAL HISTORY

List any other medical problems you have:_____

_____

List by date any hospitalizations for problems other than asthma: _____

_____

List any surgeries and dates· _____

REVIEW OF SYSTEMS (Where asked check yes or no)

Heart:	Have you ever had a heart murmur or irregular heart beat?	☐ Yes ☐ No
	Have you ever fainted or passed out?	☐ Yes ☐ No
	Do you have coronary artery disease?	☐ Yes ☐ No
GI:	Do you have frequent loose stools?	☐ Yes ☐ No
	Do you have abdominal pain?	☐ Yes ☐ No
	Do you have difficulty swallowing, pain with swallowing?	☐ Yes ☐ No
	Do you have heartburn or a history of GERD?	☐ Yes ☐ No
	Have you had any liver problems, such as hepatitis?	☐ Yes ☐ No
Nervous system:	Any chronic neurological problems?	☐ Yes ☐ No
	Do you have chronic anxiety?	☐ Yes ☐ No

Do you suffer from depression? ☐ Yes ☐ No ☐ Other concerns_____

If female: Are you pregnant, breast-feeding or planning to do so in the future? ☐ Yes ☐ No

SOCIAL HISTORY:

Do you smoke? ☐ Yes ☐ No If Yes, for how long? _____ yrs? Nr of packs/day? _____

Did you smoke in the past? ☐ Yes ☐ No If Yes, for how long? _____ yrs? Nr of packs/day? _____

When did you stop? _____

What is your occupation? _____

Any unusual hobbies or occupation exposures? _____

Are you interested in participating in a clinical research study? ☐ Yes ☐ No

To the best of my knowledge, the information provided here is correct:

Signature _____

Printed Name: _____

Date____/____/____

Provider _____

Date____/____/____ Time: ____