BOULDER MEDICAL CENTER, P.C.
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ADULT ALLERGY NEW PATIENT QUESTIONNAIRE

Name:
Age:
Date of Appointment:

INSTRUCTIONS: Please complete the following questionnaire as it is pertinent to the individual being evaluated. Completion of this form will assist us in evaluating and treating your allergy problem. Please bring the completed form with you to your appointment. Thank you.

Briefly describe the main reason for your visit and what you hope to accomplish.

Have you ever had any of the following problems? Please check *all* items either Y, N or unsure

Condition	Y	N	Unsure	Age at Onset	Comments
Asthma (Wheezing)					
Other Breathing problems (cough, shortness of breath, frequent "chest colds")					
Sinus infections					
Nasal Polyps					
Hay fever (runny/stuffy/itchy nose)					
Hives or swelling					
Eczema					
Reactions to Foods (please list)					
Reactions to Drugs (please list)					
Reactions to Insect Stings					
Additional Comments:					

Have you ever had any of the following symptoms?

Symptoms	Y/N	How many days in the last month	Severity mild, moderate, severe	Worst Season Spring, Summer, Fall, Winter	Comments
Runny or stuffy nose					
Itchy nose					
Sneezing					
Eyes: itching, watery					
Wheezing					
Coughing					
Wheezing or cough with exercise					
Night time awakenings due to shortness of breath or cough					
As sensation of choking or difficulty getting air in					
Skin problems					

Exacerbating Factors (Triggers)					
Please check each symptom box that that applies with exposure to the following:	**Symptom**				
	Asthma	**Nose/Sinus/Eyes**	**Eczema**	**Hives**	**Comments**
Animals (please name)					
Pollens/molds/mildews					
Respiratory infections, “Colds”					
Exercise					
Cold Air					
Foods					
Dust					
Air Pollution					
Fumes/Odors/Scents					
Car/Truck Exhaust					
Weather Changes					
Aspirin/Aspirin like drugs (ie ibuprofen, naproxen)					
Emotions/Stress					
Hormone changes/ menstruation					
Medications *(please name)*					
Work- related *(please name)*					
Other:					

Previous Allergy Evaluation and Therapy ***Please bring copies of results if possible**				
Allergy Skin Tests?	Yes No	Dates:		
Allergy RAST Testing?	Yes No	Dates:		
Allergy Injections?	Yes No	Dates:	Start:	End:
Chest X-ray or CT scan?	Yes No	Dates:		
Sinus X-ray or CT scan?	Yes No	Dates:		
Have you ever needed sinus surgery?	Yes No	Dates:		
Other:				

Medications: Please list any medications that you are currently taking for allergies (including inhalers, over the counter medications or herbal medicines) and any medications for other reasons.

Current Allergy Medications			**Other Medications**		
Name	Dose	Times per Day	Name	Dose	Times per Day

Please list any Allergy Medications you have tried in the past.

Have you ever needed to take Oral Steroids for an allergic condition? (for example prednisone, dexamethasone)

Past Medical History: Please list any other illnesses or chronic medical conditions you have had.	
Please list any other illnesses or chronic medical conditions you have had:	
Please list all hospitalizations/surgeries: Please give reason and date	
Immunizations:	
Are they up to date?	
Have you received a Pneumovax? Date:	
Do you receive a yearly influenza vaccine? Date: of last injection:	

Family History			
Please list family members with any of the following:			
Asthma		Emphysema	
Hayfever		Autoimmune diseases	
Eczema		Cancer	
Food Allergies		Heart Disease	
Hives		Diabetes	
Cystic Fibrosis		Glaucoma	
Recurrent infections		Other	

Social History:		
Marital Status: Single Married/Partner Divorced Separated Widowed		
Occupational History: (please list most recent job first)		
Job Title/Description	Dates	Please list any health risks/exposures
Has your illness impacted your job performance?		
Do you have any hobbies that have potential exposures and/or affect your symptoms?		
Do you or have you ever smoked cigarettes? Number of years: Avg # of cigarettes/day: Age Quit: Current # of cigarettes/day:		
Other tobacco use? Type: Amount:		
Have you/do you have second hand smoke exposure?		
Do you have a history of any other type drug use (ie marijuana, cocaine)? Yes No If yes what type and was it inhaled or IV?		
Average amount of alcoholic beverages per week:		

Environmental History			
Residence: Please list your current/past residences (city, state) with the current address first			
City/Town & State		# of Years	Effect on Symptoms/Exposures
Please check all that apply regarding your current residence:			
	Smokers in home?		Wall-to-wall carpet?
	Pets/Birds in home? (what?)		Do you vacuum?
	Swamp Cooler?		Air purification system?
	Air conditioning?		Pillow and mattress encasings?
	Humidifier?		Leaking roof or basement?
	Heating? (type: forced air, electric, water)		Mold or Mildew?
	Fireplace? (type: gas or wood burning)		Located near a busy road?
	Wood burning stove?		Other: