

# Alvernon Allergy & Asthma, P.C.

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## ADULT ALLERGY QUESTIONNAIRE

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_  
Primary Care Physician: \_\_\_\_\_ Referred by Dr. \_\_\_\_\_  
Also notify Dr. \_\_\_\_\_

1. Describe what brings you to Alvernon Allergy and Asthma. \_\_\_\_\_  
\_\_\_\_\_

2. Please **circle** the allergy related problems, which bring you to our office today.

NOSE	EYES	EARS	MOUTH/THROAT	CHEST	SKIN
sneezing	itching	itching	sore	cough	itching
itching	burning	fullness	itching	shortness of breath	hives
stiffness	swelling	popping	swelling	wheezing	rash
mouth breathing	bloodshot	hearing loss	post-nasal drip	sputum (color _____)	

3. How long have you had the symptoms related to this visit? \_\_\_\_\_

4. Symptoms or problems are: ( ) same all year round ( ) worse in the circled months:  
Jul Aug Sept Oct Nov Dec Jan Feb Mar Apr May Jun

5. Please **circle**, which make the symptoms worse.

Stress	Exercise	Infections (colds, etc.)	Wind
Heat	Dampness	Cool temperatures	Sunlight
Heaters	Air Conditioning	Evaporative Coolers	Weather Changes

6. **Specific Exposures:** (Please **circle** the exposures, which will make the symptoms worse.)

House dust	Outdoor dust	Mowing lawn
Musty places	Pets or other animals	Barns or stables
Food preparation	Gardening	Chemicals
Smoke	Perfumes	Paint
Cosmetics	Other: _____	

7. Are there any foods you avoid or suspect cause your symptoms? (Circle if Yes)

Eggs	Peanuts	Milk	Nuts	Wheat
Fish	Shellfish	Fruit	Other: _____	

8. How long have you lived in Southern Arizona? \_\_\_\_\_ years/months  
Have you had allergy tests? ( ) Yes ( ) No If Yes, when? \_\_\_\_\_ Where? \_\_\_\_\_  
Were they skin tests? ( ) Yes ( ) No or other type of tests (explain): \_\_\_\_\_  
Allergy shots taken in the past? ( ) Yes ( ) No How long ago? \_\_\_\_\_ yrs  
Did they help your symptoms? ( ) Yes ( ) No Why were they stopped? \_\_\_\_\_

9. Have you ever had a reaction to an insect sting or bite? ( ) Yes ( ) No  
If Yes, when? \_\_\_\_\_ Type of reaction: \_\_\_\_\_  
Treatment: \_\_\_\_\_

10. **Treatment:**

Prescription or "over the counter" medications you are **presently taking for allergies, asthma, hives or eczema, including those stopped** in preparation of this visit: (inhalers, drops, tablets etc.).

Medication Taken	Is the Medication Effective?	Side Effects
1) _____	_____	_____
2) _____	_____	_____
3) _____	_____	_____
4) _____	_____	_____

Prescription or "over the counter" medications **tried in the past for allergies, asthma, hives or eczema.**

\_\_\_\_\_

Please continue on next page.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Medications currently taken for other medical conditions (include herbal or health store products):

- 1) \_\_\_\_\_ 4) \_\_\_\_\_ 7) \_\_\_\_\_
- 2) \_\_\_\_\_ 5) \_\_\_\_\_ 8) \_\_\_\_\_
- 3) \_\_\_\_\_ 6) \_\_\_\_\_ 9) \_\_\_\_\_

11. Reactions to medications. Please list all medications, prescribed or over the counter, which have caused adverse reactions:

12. Past Medical History (Please list other medical conditions you have or have had in the past):

- 1) \_\_\_\_\_ 3) \_\_\_\_\_ 5) \_\_\_\_\_
- 2) \_\_\_\_\_ 4) \_\_\_\_\_ 6) \_\_\_\_\_

Hospitalizations or Operations: ( ) No ( ) Yes, when and what for: \_\_\_\_\_

13. Family History: Is there allergic rhinitis, asthma or eczema in any family members?:

Brothers or sisters (list) \_\_\_\_\_

Parents (list) \_\_\_\_\_

Grandparents (list) \_\_\_\_\_

Are there other medical issues that seem to run in the family? \_\_\_\_\_

14. Your Occupation: \_\_\_\_\_ Spouse's Occupation: \_\_\_\_\_

Hobbies: \_\_\_\_\_

15. Environment and exposures (please circle):

- Type of Home: House Apartment Manufactured Home
- Age of Home: less than 5 yrs 5 –15 yrs over 15 yrs old
- Heating system: Gas Electric Heat pump Space heaters
- Cooling system: Evaporative cooler Air conditioning Fans only
- Fireplace: yes but not used no
- Stove: Gas Electric
- Number of inside pets: Cats \_\_\_\_\_ Dogs \_\_\_\_\_ Birds \_\_\_\_\_ Other \_\_\_\_\_
- Sleeping place of the pets: \_\_\_\_\_ Outside pets: \_\_\_\_\_
- House plants: less than 20 more than 20
- Is your **bedroom** carpeted? Yes No
- Type of mattress: Regular inner spring Foam Waterbed Dust covers?
- Type of pillows: Feather or Down Foam Synthetic Dust covers?
- Bedding: Comforters Quilts Wool blankets Other: \_\_\_\_\_

- Landscape: Desert Non-desert
- Grass: Type: \_\_\_\_\_
- Trees: Mulberry Olive Mesquite Cottonwood Other: \_\_\_\_\_
- Weeds: yes no

16. Habits:(please circle)

- Do you smoke? Yes / No Cigarettes / Cigars how many per day? \_\_\_\_\_
- If No, have you ever? Yes / No from \_\_\_\_\_ to \_\_\_\_\_
- Are there smokers in the home? Yes / No
- Do you use alcohol? Yes / No Recreational drugs? Yes / No

17. Review of Systems (Please circle all that apply at the time of this appointment):

- General Health:** unexplained weight loss or weight gain, unexplained fevers, poor sleep, heat or cold intolerance
- Skin:** excessive itch, easy bruising
- Eyes, ears, nose and throat:** vision changes, ear pain, hearing loss, nose bleeds, sore throat, hoarse voice
- Heart:** chest pain, dizziness, difficulty walking short distances, unable to sleep flat, extra fluid in feet/legs
- Lungs:** blood tinged sputum
- Gastrointestinal:** heartburn, regurgitation, problems swallowing, diarrhea, constipation, stomach pain
- Kidney/urinary:** pain with urination, blood in urine, frequent urination
- Muscles, Bones or Joints:** joint pain, joint swelling, decreased joint mobility, broken bones
- Nervous System:** frequent headaches, seizures
- Mental Health:** anxiety, depression, excessive "worry"

Questionnaire incl. ROS reviewed with patient: \_\_\_\_\_

NURSES USE ONLY HT \_\_\_\_\_ WT \_\_\_\_\_ BP \_\_\_\_\_ PULSE \_\_\_\_\_ RR \_\_\_\_\_