Northeast Georgia
PHYSICIANS GROUP

# Allergy and Asthma New Patient Form

| Name: | Date of Birth: | Date: |
|---|---|---|

| **Patient Questionnaire** | | | | |
|---|---|---|---|---|
| Have you experienced any **Nasal/Sinus symptoms**? (Circle one) | Yes | No | | |
| (if yes, please answer questions below; if no, skip and go to the Eye Symptoms section) | | | | |
| When did the symptoms start? What was your age or the year? | | Age: | Year: | |
| Intensity (Circle all that apply) | Mild | Moderate | Severe | |
| Symptoms (Circle all that apply) | Runny nose<br>Stuffy nose<br>Sneezing<br>Throat clearing | Itchy mouth<br>Itchy throat<br>Itchy nose<br>Itchy ears | Headache<br>Sinus pressure/pain<br>Post Nasal Drip<br>Cough | Nosebleeds: circle<br>Drops of blood ? Or<br>Gushing blood?<br>How frequent? |
| Timing: (Choose one of the following three options): | Year-round | Seasonal: (please circle all problem seasons): Spring<br>Summer<br>Fall<br>Winter | Year-round with seasonal worsening (which seasons worse, please circle):<br>Spring<br>Summer<br>Fall<br>Winter | |
| Medication taken: (Circle all that apply and whether it was helpful or not): | Fexofenadine (Allegra): helpful, or not helpful | | Benadryl: helpful, or not helpful | |
| | Loratadine (Claritin): helpful, or not helpful | | Flonase/fluticasone: helpful or not helpful | |
| | Cetirizine (Zyrtec): helpful, or not helpful | | Afrin: helpful, or not helpful | |
| | Levocetirizine (Xyzal): helpful, or not helpful | | Other: helpful, or not helpful | |
| Past allergy testing? (Circle one of the following):<br>Yes or No | If Yes: When was the test performed?<br><br>Age or year: ______________ | If Yes, what were the results (Circle all that apply): Pets<br>Pollen<br>Dust<br>Cockroach<br>Mold | Allergy shots received? (Circle one): Yes or No<br>If yes, how long on shots? ____________________<br>Were they helpful? (Circle one): Yes or No | |
| Infections: (Circle all that apply): | Sinusitis: how many per year? _________<br>Are antibiotics given every time?<br>(Circile one): Yes or No | | Bronchitis: how many per year? _________<br>Are antibiotics given every time?<br>(Circile one): Yes or No | |
| | Pneumonia: how many per year? _________ Are antibiotics given every time?<br>(Circile one): Yes or No | | | |

Northeast Georgia PHYSICIANS GROUP

# Allergy and Asthma New Patient Form

| EYE SYMPTOMS: (Circle one) | Yes | No | | |
|---|---|---|---|---|
| (if yes, please answer questions below; if no, go to the Breathing Symptoms section) | | | | |
| When did the symptoms start? What was your age or the year? | | Age: | Year: | |
| Symptoms (Circle all that apply) | Itchy | Puffy | Particular triggers:<br>(Circle all that apply)<br>Pollen<br>Pets<br>Unknown<br>Other: ____________ | Eye drops used:<br>(Circle one): Yes or No<br>If yes, name of the drops?<br>____________________<br>Was it helpful?<br>(Circile one): Yes or No |
| | Watery | Red | | |

| BREATHING SYMPTOMS: (Circle one) | Yes | No | | |
|---|---|---|---|---|
| (if yes, please answer questions below; if no, go to the GERD section) | | | | |
| When did the symptoms start? What was your age or the year? | | Age: | Year: | |
| Symptoms (Circle all that apply) | Cough | Shortness of Breath | Chest tightness: | Wheezing |
| | In the past month, symptoms more than twice a week? (Circle one): Yes or No | | In the past month, night symptoms more than twice a month? (Circle one): Yes or No | |
| Triggers (Circle all that apply) | Cold air | Exercise | Smoke | Emotions: such as Sadness, Anxiety Excitement |
| | Humid air | Certain Pets | Certain Seasons | |
| | Infection | Strong Odors | Taking Aspirin | |
| Hospitalizations for asthma (Circle one): | Yes | No | | |
| Medications taken: | Yes | No | If yes, was the medication helpful?<br>(Circile one): Yes or No | |
| Current medications: | | | | |
| Were you seen by a lung doctor (Pulmonologist) | Yes | No | If yes, when was your last visit? ________________ | |

| Gastroesophageal Reflux Disease: (Circle one) | Yes | No | | |
|---|---|---|---|---|
| (if yes, please answer questions below; if no, go to the Hives/Swelling section) | | | | |
| When did the symptoms start? What was your age or the year? | | Age: | Year: | |
| What are your Triggers | | | | |
| Medications taken: | Yes | No | If yes, was the medication helpful?<br>(Circile one): Yes or No | |
| Current medications: | | | | |

Northeast Georgia PHYSICIANS GROUP

# Allergy and Asthma New Patient Form

| HIVES / SWELLING: (Circle one) | Yes | No | | | |
|---|---|---|---|---|---|
| (if yes, please answer questions below; if no, go to the Eczema section) | | | | | |
| When did the symptoms start? What was your age or the year? | Age: | | Year: | | |
| Hives: located on your body | | | | | |
| How often do you breakout? (Circle one) | Daily | Most days of the week | Less than 2 days a week | Once or twice a month | Less than once a month |
| How long do the hives last once they start? (Circle one) | Hours | Days | Are they itchy? Yes or No | | |
| Is there any swelling? (Circle one) | Yes | No | If Yes, what location on your body (circle all that apply) Face, arms, chest, back, buttocks, legs, other: ________________ | | |
| How often is there swelling: (Circle one) | Daily | | Once or twice a month | | |
| | Most days a week | | Less than once a month | | |
| | Less than 2 days a week | | | | |
| What are your Triggers? (Circle all that apply) | Certain food(s) | Certain Med(s) | Insect Stings | Latex | Heat / Cold |
| | Taking Aspirin | Pressure on skin | Contact with Pet | Infection | Stress |
| Medications taken: | Yes | No | If yes, was the medication helpful? (Circle one): Yes or No | | |
| Current medications: | | | | | |
| Autoimmune disease in you or your blood-related family? | Yes / No | If Yes, (Circle all that apply | Lupus / Thyroid Disease | Rheumatoid Arthritis / Chron's Disease | Ulcerative Colitis / Multiple Sclerosis |

| ECZEMA: (Circle one) | Yes | No | | | |
|---|---|---|---|---|---|
| (if yes, please answer questions below; if no, go to the Food Reaction section) | | | | | |
| When did the symptoms start? What was your age or the year? | Age: | Year: | | | |
| What are the affected area(s) located on your body? | | | | | |
| What moisturizers do you use? | Was it helpful? Yes or No | How itchy? (Circle all that apply) | Mild | Moderate | Severe |
| How itchy? (Circle all that apply) | Mild | Moderate | Severe | | |
| Medications taken: | Yes | No | If yes, was the medication helpful? (Circle one): Yes or No | | |
| Were Biologic/ Shots used? | Yes | No | Helpful? Yes or No | | |

Northeast Georgia PHYSICIANS GROUP

# Allergy and Asthma New Patient Form

| FOOD REACTIONS: (Circle one) | Yes | No | | | | | |
|---|---|---|---|---|---|---|---|
| (if yes, please answer questions below; if no, go to the Med/Drug Reaction section) | | | | | | | |
| What food caused the reaction? | | | | | | | |
| When did the symptoms start? What was your age or the year? | | Age: | | Year: | | | |
| What Symptoms? (Circle all that apply) | Itch | Lip Swelling | Throat Swelling | Cough | Chest Tightness | Dizziness | Nausea/ Vomiting |
| | Hives | Tongue Swelling | Shortness of Breath | Wheezing | Light-Headedness | Stomach Discomfort | Diarrhea |
| How quickly did the reaction occur after eating food? | | | | | | | |
| How many bites were eaten before the reaction? _______________ | | | | | | | |
| Were medications taken to stop the reaction? | Yes | No | Were they helpful? | Yes | No | | |
| Did you go to Urgent Care, ED, or your Primary Care office? | Yes | No | Did you get an Epinephrine auto-injector? | Yes | No | | |
| Have you eaten the food again? If yes, please answer below | Yes | No | If yes, did you have the same reaction? | Yes | No | | |

| MEDICATION/DRUG REACTION: (Circle one) | Yes | No | | | | | |
|---|---|---|---|---|---|---|---|
| (if yes, please answer questions below; if no, go to the Sting/Bite Reaction section) | | | | | | | |
| What medication causes a reaction? | | | | | | | |
| When did this happen? What was your age or the year? | | Age: | | Year: | | | |
| What Symptoms? (Circle all that apply) | Itch | Lip Swelling | Throat Swelling | Cough | Chest Tightness | Dizziness | Nausea/ Vomiting |
| | Hives | Tongue Swelling | Shortness of Breath | Wheezing | Light-Headedness | Stomach Discomfort | Diarrhea |
| How quickly did the reaction occur after taking the medication? ________ | | | Were they helpful? | Yes | No | | |
| Medications taken to stop the reaction? | Yes | No | Were they helpful? | Yes | No | | |
| Did you go to Urgent Care, ED, or your Primary Care office? | Yes | No | Did you get an Epinephrine auto-injector? | Yes | No | | |
| Have you taken the medication again? | Yes | No | If yes, did you have the same reaction? | Yes | No | | |

| STING/BITE REACTION: (Circle one) | Yes | No | | | | | |
|---|---|---|---|---|---|---|---|
| (if yes, please answer questions below; if no, go to the Sting/Bite Reaction section) | | | | | | | |
| When did this happen? What was your age or the year? | | Age: | | Year: | | | |
| Insect? | Yes | No | What insect? | | | | |
| What Symptoms? (Circle all that apply) | Itch | Lip Swelling | Throat Swelling | Cough | Chest Tightness | Dizziness | Nausea/ Vomiting |
| | Hives | Tongue Swelling | Shortness of Breath | Wheezing | Light-Headedness | Stomach Discomfort | Diarrhea |
| How quickly did the reaction occur after the sting? ___________________ | | | Were they helpful? | Yes | No | | |
| Medications taken to stop the reaction? | Yes | No | Were they helpful? | Yes | No | | |
| Did you go to Urgent Care, ED, or your Primary Care office? | Yes | No | Did you get an Epinephrine auto-injector? | Yes | No | | |
| Have you gotten stung again? | Yes | No | If yes, did you have the same reaction? | Yes | No | | |

Northeast Georgia
PHYSICIANS GROUP

# Allergy and Asthma New Patient Form

## ENVIRONMENTAL HISTORY

| How long have you lived in your current home? | How old is your home? |
|---|---|

| How many people are living in your home? | Anything unusual or remarkable about this home? |
|---|---|

| Question | | | | | | |
|---|---|---|---|---|---|---|
| What type of home do you live in? | House | Apartment | Mobile Home | Condo | Townhome | |
| What is your home made of? | Brick | Wood | Siding | Block | Stucco | Other |
| What type of mattress do you have? | Foam | Inner Spring | Waterbed | | | |
| What type of pillow do you use? | Feather | Feather | Other | | | |
| What type of flooring is in your home? | Carpet | Wood | Linoleum | Tile | Other | |
| What type of air conditioning does your home have? | None | Window Unit | Central | | | |
| What type of heat does your home have? | Electric | Gas | Wood | Oil | Kerosene | |
| How much moisture is in your basement? | None | Dry | Damp | Very Wet | I don't know | |
| How often are the Heat/Air filters changed in your home? | | | | | | |
| Do you have any pets in your home? | Yes | No | | | | |

Please list the type of pet and whether they live indoors or outdoors:

| | | | |
|---|---|---|---|
| | | | |
| | | | |

| Are there any smokers living in your home? | Yes | No | |
|---|---|---|---|

Please list who smokes and if they smoke indoors or outdoors:

| | | | |
|---|---|---|---|
| | | | |
| | | | |

## OTHER

Any other concerns?