VALLEY ENT
superior medical care, right in your neighborhood

New Patient Medical History and Allergy Survey

Please complete this form. It is important for your doctor to know the details about your medical history and allergy symptoms. If you have questions about completing this form, please ask the medical office staff.

Name: _____ **Age** _____ **Date** _____

Primary Care Physician's Name: _____

Referring Physician's Name: _____

Chief complaint(s) and onset:

_____
_____
_____
_____

Expectations from this allergy/immunology consultation:

_____
_____

Do you have any of the following:

Asthma	Yes____	No____	Uncertain____	Date of Onset_____
Exercise induced asthma	Yes____	No____	Uncertain____	Date of Onset_____
Allergies/hayfever	Yes____	No____	Uncertain____	Date of Onset_____
Hives/Urticaria	Yes____	No____	Uncertain____	Date of Onset_____
Rash	Yes____	No____	Uncertain____	Date of Onset_____
Eczema	Yes____	No____	Uncertain____	Date of Onset_____
Food allergy	Yes____	No____	Uncertain____	Date of Onset_____
Drug allergy	Yes____	No____	Uncertain____	Date of Onset_____
Insect allergy	Yes____	No____	Uncertain____	Date of Onset_____
Headache	Yes____	No____	Uncertain____	Date of Onset_____
Anaphylactic reaction	Yes____	No____	Uncertain____	Date of Onset_____

Other (please describe): _____

Allergy evaluation:

Have you ever been evaluated by an allergist/immunologist? Yes_____ No_____
Name of previous allergist:_____ Date last seen:_____
City/State of previous allergist:_____
Have you had any "blood work" to determine if you have allergies? Yes____ No____
Have you ever been "skin tested" to evaluate allergies? Yes_____ No_____ Uncertain_____

If "yes", what were you allergic to (check all that apply):
Trees____ Grasses____ Weeds____ Cats____ Dogs____ Dust mites____ Molds____
Cockroaches____ Food____

Have you ever been on "allergy injections/immunotherapy"? Yes_____ No_____ Uncertain_____
If "yes": When did you start:_____ How long did you receive immunotherapy?_____ Did you find it beneficial? Yes_____ No_____ Uncertain_____ Did you have any significant reactions after injections: No___ Yes___ Describe:_____

Nasal and Eye Allergy Symptoms:

Onset of allergy symptoms (age): _____
How long have you lived in Arizona? _____
Where have you previously lived? _____
Do you have daily symptoms: Yes ____ No _____ Seasonal _____
Are your allergy symptoms getting worse: Yes _____ No _____ Constant_____
What time of year are your allergy symptoms the worst (check all that apply):

Spring _____ Summer _____ Fall _____ Winter _____
Do any particular exposures make your allergies worse (check all that apply): Cats ____ Dogs ____ Smoke ____ Grass ____
Perfume _____ Strong odors _____ Other allergy triggers:
_____
How is your sense of smell: Excellent____ Good ____ Poor _____
None _____ Do you have discolored nasal discharge? Yes____ No____
If yes, what color and how long have you had it? Color:_____
Onset:_____
Check all allergy symptoms that you have: Eyes: Itching___ Swelling___ Burning ___ Runny ___ Watery___ Discharge___
Pain___ Ears: Itching___ Fullness___ Popping___ Decreased hearing___ Pain___ Nose: Itching___ Sneezing___
Runny nose___ Congestion___ Stuffy nose___ Obstruction___
Mouth breathing___ Nasal pressure or pain___ Nasal polyps___
Throat: Itching___ Soreness___ Post nasal drip___ Throat clearing___ Swelling___
How many times in a row do you sneeze?_____
Do you currently use a nasal spray? Yes____ No____ Name of product:_____
Do you currently use an antihistamine? Yes____ No____ Name of product:_____
Do you ever use nasal saline spray? Yes_____ No_____ Never_____
Do you use nasal saline irrigation? Yes_____ No_____ Never_____
Do you use "Afrin" or other over the counter nasal decongestant spray? Yes___ No___
If "yes", for how long:_____
Have you ever had a CT (CAT scan) of your sinuses? Yes____ No____
If "yes", Date/results:_____

Have you ever had sinus surgery? Yes_____ No_____ If "yes", when:_____

Have you been evaluated by an ENT/Otolaryngolagist? Yes___ No___ If "yes", who and when:_____

Respiratory:

Do you cough? Yes____ No ____ Onset of cough: _____
Do you wheeze? Yes___ No_____Onset of wheezing:_____
Have you ever been diagnosed with any of the following:
Asthma: Yes_____ No_____ Age of diagnosis:_____
COPD: Yes_____ No_____ Age of diagnosis:_____
Emphysema: Yes_____ No_____ Age of diagnosis:_____
Pneumonia: Yes_____ No_____ Age of diagnosis:_____ How many times:_____
Bronchitis: Yes_____ No_____ Age of diagnosis:_____

Do you cough at night? Yes_____ No_____ How many times per month:_____
Do you wheeze at night? Yes_____ No_____ How many times per month:_____
Do you cough with activity? Yes_____ No_____ How many times per month:_____
Do you wheeze with activity? Yes_____ No_____ How many times per month:_____
What activities cause you to cough or wheeze (check all that apply):
Walking___ Walking up stairs___ Running___ Exercise___
Do you cough when you laugh? Yes____ No_____
Have you had a chest X-ray? Yes____ No____ Date/results:_____
Have you had a chest CAT Scan? Yes____ No____ Date/results:_____

Have you had lung function testing? Yes____ No____ Date/results:_____
Do you currently use "Albuterol"? Yes____ No____ Nebulizer____ Meter dose inhaler_____
How many times per week do you use Albuterol?_____
Do you use any other respiratory medications? Yes____ No____
Have you used any of the following medications (check all that apply):
Advair___ Flovent___ Pulmicort___ Asmanex___ Qvar___ Foradil___ Serevent___
Combivent___ Singulair___ Albuterol___
If "yes", did any of the medications help your breathing: Yes___ No___ Uncertain___
Which medications helped you the most (check all that apply):
Advair___ Flovent___ Pulmicort___ Asmanex___ Qvar___ Foradil___ Serevent___
Combivent___ Singulair___ Albuterol___

What triggers your respiratory symptoms (check all that apply):
Upper respiratory infection____ Change in weather___ Exercise___ Cold weather___ Hot weather___ Wind___
Smoke___ Strong odors____ Perfume____ Work related____
Have you ever been intubated or on a ventilator? Yes____ No____
Have you ever been admitted to the ICU or PICU? Yes____ No____
How many times in your life have you been on oral steroids:_____
When was your last course of oral steroids:_____
Have you ever had a "bone density" study? Yes____ No____
Do you have osteopenia? Yes____ No____ Do you have osteoporosis? Yes____ No____
Do you use a peak flow meter? Yes___ No___ If "yes", what is your best peak flow (liters/min):_____

Eczema:
Have you ever been diagnosed with eczema? Yes____ No____ (If "No", go to next section)
Age at onset of eczema? _____
Triggers of eczema (check all that apply):

Food allergy____ Milk____ Egg____ Nut____ Cat____ Dog____ Dry weather____ Cold weather____
Grass exposure____ Swimming pool____ Bathing____ Other:_____
Do you use daily moisturizer? Yes_____ No_____
Do you use a topical steroid? Yes____ No____
Have you ever had a severe skin infection requiring antibiotics? Yes____ No____ How many times? _____
Do you have a dermatologist? Yes_____ No_____ Name of physician:_____
Have you been evaluated for food allergy? Yes____ No____

Rash: (If NO rash, don't complete this section)
When did your rash first start?_____
On what part of your body did your rash first appear? _____
Has your rash gotten: Better____ Worse____ No change_____
Does your rash "come and go"? Yes____ No____ Constant_____
Describe the circumstances surrounding the onset of your rash:_____

What do you think caused your rash? _____
Does the rash itch: Yes ____ No____ Uncertain_____
What size are the individual rash lesions? _____
What time of day is your rash worse? AM_____ PM_____ No difference_____
Is there any pattern or cycle that your rash follows? No____ Yes____ Describe:_____
Have you identified any place where your rash is worse? (check all that apply):

Indoors___ Outdoors___ Home___ Work___ School___ Vacation___ No difference___ Other:_____

What medications have you used to control your rash:
1. _____ Effective____ Not effective____
2. _____ Effective____ Not effective____
3. _____ Effective____ Not effective____
4. Steroids:_____ Effective____ Not effective____

Do any of the following factors trigger your rash or make it worse? (check all that apply)
Aspirin___ Alcohol___ Food___ Cold___ Heat___ Hot bath___ Water___ Exercise___ Emotions___

Sunlight___ Exertion___ Sweating___ Vibration___ Medication___ Metal exposure___ Tight clothes___
Have you had any of the following symptoms associated with your rash? (check all that apply)
Excessive sweating___ Diarrhea___ Headaches___ Abdominal cramps___ Fever___ Muscle pains___ Joint swelling___ Joint pain___ Joint stiffness___ Fatigue___
Have you traveled outside of the United States immediately prior to onset of the rash? No____ Yes____ Where:_____

Did you start any new medications prior to the onset of the rash? No___ Yes___ Medication:_____

Drug Allergy:
If "no known drug allergies", place check next to none and proceed to next section: None_____ Please list all drug allergies, date, and reaction(s)
1. Drug: _____ Date/Age:_____ Reaction:_____
2. Drug: _____ Date/Age:_____ Reaction:_____
3. Drug: _____ Date/Age:_____ Reaction:_____
4. Drug: _____ Date/Age:_____ Reaction:_____
5. Drug: _____ Date/Age:_____ Reaction:_____
6. Drug: _____ Date/Age:_____ Reaction:_____
7. Drug: _____ Date/Age:_____ Reaction:_____

Food Allergy:
If "no known food allergies", place check next to none and proceed to next section: None_____ Please list all food allergies, date, and reaction(s)
1. Food: _____ Date/Age:_____ Reaction:_____
2. Food: _____ Date/Age:_____ Reaction:_____
3. Food: _____ Date/Age:_____ Reaction:_____
4. Food: _____ Date/Age:_____ Reaction:_____
5. Food: _____ Date/Age:_____ Reaction:_____
6. Food: _____ Date/Age:_____ Reaction:_____
7. Food: _____ Date/Age:_____ Reaction:_____

Do you have an EpiPen or EpiPen Jr? Yes____ No____
Have you ever used your EpiPen or received epinephrine? Yes____ No____ Uncertain____
Have you ever been seen in the Emergency Room for food allergy: Yes____ No____
Are you familiar with the Food Allergy and Anaphylaxis Network? Yes____ No____

Insect Allergy:
Have you ever had a "life threatening reaction" to a stinging insect? Yes_____ No_____
If "No", proceed to the next section, otherwise:
If "yes":
Date_____ Suspected insect_____ Reaction_____

Date_____ Suspected insect_____ Reaction_____

Date_____ Suspected insect_____ Reaction_____
Do you have an EpiPen or EpiPen Jr? Yes____ No____
Have you ever used your EpiPen or received epinephrine? Yes____ No____ Uncertain____
Have you ever been seen in the Emergency Room for insect allergy: Yes____ No____
Have you ever been on "immunotherapy" for insect allergy? Yes____ No____ Uncertain____

Environmental History:
Do you live in a: House____ Condo____ Apartment____ Mobile Home____ RV____ Assisted living____ Other_____
Do you have any pets? Yes____ No____ If "yes", how many of the following: Cats_____ Dogs_____ Hamsters____ Ferrets____ Birds____ Snakes____ Are the pets allowed inside the bedroom? Yes____ No____
Do you have carpeting in the bedroom? Yes____ No____
Do you use a humidifier? Yes____ No____ Do you use central air conditioning? Yes____ No____
Do you use a HEPA filter? Yes____ No____ Do you use an "Ionic Breeze" or similar? Yes____ No____
How many people live with the patient (number): _____

Who lives with the patient (i.e. mom, dad, wife, etc.): _____
Does anyone who lives with the patient smoke? Yes____ No____
Does anyone smoke in the house? Yes____ No____ Does anyone smoke in the car? Yes____ No____

Birth History: *(Only to be completed if the patient is < 10 years old)*****
Place of birth (city/state):_____
Full term: Yes____ No____ If "No", how many gestational weeks:_____
Check type of birth: Vaginal birth _____ OR C-Section _____
Birth Weight: _____
Did the baby stay in the NICU? No_____ Yes_____ If "yes", for how long?: _____ Ventilator? Yes____ No____
Complications: No ____ Yes____ If "Yes", please describe:_____
Breast fed: Yes___ No___ If "yes", for how long:_____
Formula type: Cow's milk based____ Soy___ Lactose Free___ Nutramigen___ Alimentum___ Other_____
Age started solid foods:_____

MEDICATIONS
Please list all current medications and reason for taking:
1. _____ Reason for taking: _____
2. _____ Reason for taking: _____
3. _____ Reason for taking: _____
4. _____ Reason for taking: _____
5. _____ Reason for taking: _____
6. _____ Reason for taking: _____
7. _____ Reason for taking: _____
8. _____ Reason for taking: _____
9. _____ Reason for taking: _____
10. _____ Reason for taking: _____

Please list all over the counter and herbal/vitamins that you are taking:
1. _____ Reason for taking: _____
2. _____ Reason for taking: _____
3. _____ Reason for taking: _____
4. _____ Reason for taking: _____
5. _____ Reason for taking: _____
6. _____ Reason for taking: _____
7. _____ Reason for taking: _____
8. _____ Reason for taking: _____

PAST MEDICAL HISTORY
Operations/Surgery (Name and date of procedure)
1. _____
2. _____
3. _____
4. _____
5. _____
Hospitalizations (Where, reason, date, and length of stay)
1. _____
2. _____
3. _____
4. _____
5. _____

Medical Problems (Problem and date diagnosed)
1. _____
2. _____
3. _____
4. _____
5. _____

6. _____
7. _____
8. _____
9. _____
10. _____

Immunizations:

Are your immunizations up to date? Yes____ No____
Have you had a recent influenza vaccine? Yes___ No____ Date of last dose:_____
Have you had a Pneumovax / Prevnar (Pneumonia) vaccine? Yes____ No____ Date of last dose:_____
Date of last tetanus vaccine:_____

Social History: (Adults and adolescents)

Do you smoke (check all that apply)? Yes____ No____ Never_____ Quit _____
If "yes", how much do you smoke? _____ packs per day Age started:_____
If you "quit", when did you quit? _____ How many years did you smoke? _____
How many packs did you smoke per day (average)?_____
Are you exposed to "passive smoke" from another household member? Yes___ No___
Do you drink alcohol? Yes____ No____ Average drinks per day: _____
Type of alcohol: Beer___ Wine___ Liquor___
Do you use "recreational drugs"? Yes___ No___ If "yes", what type:_____
Do you consider yourself at "high risk" for HIV? No___ Yes___ If "yes", why:_____
Have you ever had a blood transfusion? No___ Yes___ If "yes", why:_____
Caffeine use (drinks/day):_____
Exercise (times/week): _____ Type of exercise:_____
Seatbelt use (%): 100___ 75___ 50___ 25___ Never___
Sun exposure: Frequently___ Occasionally___ Rarely___ Sunscreen use: Frequently___ Occasionally___ Rarely___
Occupation:_____
Exposure to toxic or noxious chemical/substances: No____ Yes____ Describe:_____

Social History: (If < 13 years old)

Is the patient exposed to "passive smoke" from another household member? Yes___ No___
Seatbelt use (%): 100___ 75___ 50___ 25___ Never___
Sun exposure: Frequently___ Occasionally___ Rarely___
Sunscreen use: Frequently___ Occasionally___ Rarely___
Blood transfusion? No___ Yes___ If "yes", why:_____
Daycare: Yes____ No____ If "yes", age started attending:_____
School: Yes____ No____ Grade:_____ Performance: Excellent___ Good___ Fair___ Poor___

Immunology Evaluation: (Only complete if you have immune system problems or frequent infections since birth)

Have you ever been diagnosed with a primary immunodeficiency? No___ Yes___
If "yes", please describe:_____
Have any family members ever been diagnosed with an immunodeficiency? No___ Yes___
If "yes", please describe:_____
Have you ever been diagnosed with any of the following: (check all that apply)
Pneumonia___ Meningitis___ Osteomyelitis___ Sepsis___ Severe skin infection___ Bronchiectasis___
Cystic Fibrosis___ IgA deficiency___ HIV___ AIDS___ Antibody deficiency___ Complement deficiency___
Common Variable Immunodeficiency___ Other:_____
How many times have you had pneumonia? _____ How many per year? _____
How many sinus infections have you had in your life? _____ How many per year? _____
How many ear infections have you had in your life? _____ How many per year? _____
How many throat infections have you had in your life? _____ How many per year? _____
Have you ever received intravenous immunoglobin (IVIG) therapy? No___ Yes____
If "yes", please describe: _____
Have you ever been evaluated for primary immunodeficiency? Yes____ No____
Have you ever been tested for HIV? Yes___ No___ If "yes", last date and result:_____

Patient Name _____ DOB _____ DOS _____

Review of Systems

Do you currently have any of the following? (Check)

Allergy
___Asthma
___Hay fever
___Drug allergy
___Food allergy
___ Insect allergy
___Recurrent infections
___Recurrent ear infections
___Recurrent sinus infections
___Recurrent pneumonia

General
___Fever
___Chills
___Night sweats
___Poor appetite
___Fatigue/Weakness
___Weight loss
___Weight gain
___Sleep disorder
___Headaches
___Facial pain
___Depression
___Anxiety

Eyes
___Eye itching
___Eye swelling
___Eye burning
___Eye tearing
___Eye discharge
___Eye irritation
___Vision loss
___Eye pain
___Photophobia

Ears
___Itchy ears
___Ear pain
___Ear discharge
___Ringing
___Decreased hearing
___Popping of ears
___Fullness of ears

Nose/Throat
___Nasal congestion
___Sneezing
___Itchy nose
___Runny nose
___Discolored nasal discharge
___Nosebleeds
___Post nasal drip
___Nasal obstruction
___Sore throat
___Hoarseness
___Itchy throat
___Frequent throat clearing
___Throat swelling

Cardiovascular
___Chest pains
___Palpitations
___Chest pain with exercise
___Ankle swelling

Respiratory
___Cough
___Coughing at night
___Wheezing
___Wheezing at night
___Wheezing with activity
___Exercise induced cough
___Reduced exercise tolerance
___Discolored sputum
___Coughing up blood
___Snoring

GI
___Nausea
___Vomiting
___Diarrhea
___Constipation
___Change in bowel habits
___Abdominal pain
___Gas/bloating
___Indigestion/heartburn
___Difficulty swallowing
___Frequent burping
___Frequent belching
___Sour taste in mouth/throat

Derm
___Hives
___Eczema
___Swelling
___Rash
___Itching
___Dry skin
___Suspicious lesions

Family History

Are there any members of the immediate family who have asthma, hay fever, eczema, rash, food allergies, drug allergies, insect allergies, arthritis, recurring and/or frequent infections? Please list and comment.

_____
_____
_____
_____

Are there any hereditary diseases or other disorders that seem to occur frequently in your family (diabetes, emphysema, heart problems)?

_____
_____
_____

Comments

_____
_____
_____
_____
_____
_____

I have answered the entire questionnaire to best of my knowledge.

_____
Patient signature

I have reviewed the entire form with the patient.

_____
Amy Shah, M.D.

Patient Consent for Photography

Patient Name: _____ DOB: _____ Date: _____

I _____ hereby authorize Amy Shah, M.D. and Valley ENT, PC. to take photographs of me or my child in whole or part. I understand that these photographs may be used for medical purposes, such as documenting or planning my care.

This photo will be used in the chart in our electronic medical records area. The photo helps to identify patients and prevent medical errors.

_____ _____

Signature of Patient or Guardian Date