Patient Name: _____ **DOB:** ___/___/_____

Allergy/Immunology
Adult New Patient - Health History Questionnaire

Medication Allergies
List all known medication allergies OR check ☐ if there are no known drug allergies

Medication	Reaction	Date (approx.)
1.		
2.		
3.		
4.		

Current Medications
List all current medications. Include prescribed and over the counter drugs, including vitamins. Include medications taken every day and medications taken only when needed.

Medication	Dosage	Frequency	Start Date (approx.)
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Vaccines
Check all that you have received.

☐ Influenza	Date received (approx.) ____ / ____
☐ Pneumococcal conjugate, PCV 13	Date received (approx.) ____ / ____
☐ Pneumococcal polysaccharide, PPV 23	Date received (approx.) ____ / ____
☐ Td (tetanus, diptheria)	Date received (approx.) ____ / ____
☐ Tdap (tetanus, diptheria, pertussis)	Date received (approx.) ____ / ____

Past Surgical History:
Check all surgeries that apply OR check ☐ if there are no previous surgeries

☐ Adenoidectomy	☐ Gynocologic Surgery	☐ Tonsillectomy
☐ Appendectomy	☐ Hysterectomy (ovaries remain)	☐ Tonsillectomy/Adenoidectomy
☐ Back/Spine Surgery	☐ Hysterectomy/Oopherectomy (ovaries removed)	☐ Tubal Ligation
☐ Balloon Sinuplasty	☐ Laparoscopy	☐ Turbinate Reduction
☐ Breast Biopsy/Surgery	☐ Laparotomy	☐ Tympanostomy- Ear tubes
☐ Bronchoscopy	☐ Oncologic/Cancer Surgery	☐ Vascular Surgery
☐ Caesarean Section	☐ Plastic/Reconstructive Surgery	☐ Vasectomy
☐ Cardiac (Heart) Surgery	☐ Prostate Surgery	☐ Other: _____
☐ Cholecystectomy (Gallbladder)	☐ Pulmonary (Lung) Surgery	☐ Other: _____
☐ Colonoscopy	☐ Septoplasty	☐ Other: _____
☐ Dermatologic (Skin) Surgery	☐ Sinus Osteotomy	☐ Other: _____
☐ Gastrointestinal Surgery	☐ Sinus Surgery	☐ Other: _____
☐ Genitourinary Surgery	☐ Thyroid Surgery	☐ Other: _____

Past Medical History

Check all diseases and conditions that apply OR check □ if there are no previous diseases or conditions

- □ ADHD
- □ Anemia
- □ Anesthesia Complications
- □ Allergy- allergic conjunctivitis
- □ Allergy- contact dermatitis
- □ Allergy- environmental
- □ Allergy- food
- □ Allergy- latex
- □ Allergy- stinging insects
- □ Anaphylaxis
- □ Angioedema (swelling)
- □ Are you pregnant/planning pregnancy?
- □ Arthritis
- □ Asthma
- □ Autoimmune disease
- □ Blood clots/DVT/Pulmonary Embolism
- □ Breastfeeding/Nursing
- □ Bronchitis
- □ Cancer
- □ Cardiovascular Disease (heart disease)
- □ Cholelithiasis (Gallstones)
- □ Chronic ear infections
- □ Congenital Disorder
- □ Cystic Fibrosis
- □ Developmental or Behavioral Disorders
- □ Diabetes Mellitus
- □ Ear or Hearing Disorders
- □ Eczema
- □ Emphysema or COPD
- □ Endocrine Disorder
- □ Eosinophilic Esophagitis/Gastritis/Colitis
- □ Fibromyalgia
- □ Gastrointestinal Disease
- □ Genetic/Hereditary Disorder
- □ HIV or AIDS
- □ Hematologic (blood) Disease
- □ Hypercholesterolemia (high cholesterol)
- □ Hypertenstion (high blood pressure)
- □ IBS (irritable bowel syndrome)
- □ Immunologic Disease
- □ Insomnia
- □ Meniere's Disease
- □ Menopause
- □ Mental Illness
- □ Migraines
- □ Mood Disorder (depression, anxiety)
- □ Musculoskeletal Disease
- □ Nasal polyps
- □ Neurologic Disorder
- □ Obesity
- □ Osteopenia/Osteoporosis
- □ Pneumonia
- □ Pulmonary (lung) Disease
- □ Reflux/GERD (heartburn)
- □ Renal (kidney) Disease
- □ Sinusitis
- □ Sleep Apnea
- □ Thyroid Disease
- □ Tobacco Use
- □ Urologic Disorder
- □ Urticaria (hives)
- □ Vertigo
- □ Vision/Eye Disorder
- □ Vitamin Deficiency

Family History

Check all diseases that apply.

- □ Allergic conjunctivitis — Family member(s): _____
- □ Allergic reaction to insect venom — Family member(s): _____
- □ Allergic rhinitis (hay fever) — Family member(s): _____
- □ Angioedema (swelling) — Family member(s): _____
- □ Asthma — Family member(s): _____
- □ Autoimmune disease — Family member(s): _____
- □ Chronic obstructive lung disease — Family member(s): _____
- □ Chronic sinusitis — Family member(s): _____
- □ Cystic fibrosis — Family member(s): _____
- □ Disorder of gastrointestinal tract — Family member(s): _____
- □ Disorder if immune system — Family member(s): _____
- □ Disorder of lung — Family member(s): _____
- □ Disorder of thyroid gland — Family member(s): _____
- □ Eczema — Family member(s): _____
- □ Malignant neoplastic disease (cancer) — Family member(s): _____
- □ Recurrent bacterial infections — Family member(s): _____
- □ Urticaria (hives) — Family member(s): _____

Social History

Circle your answer(s) or fill in blanks.

Smoking Status: Never Smoker Former smoker Current every day smoker Current some day smoker

Currently Smoking: None 1 PPW 2 PPW 1/4 PPD 1/2 PPD 1PPD 1.5 PPD 2 PPD 3+ PPD

Tobacco - years of use: _____

Do you have an Advance Directive to guide your healthcare in the event you are unable to make decisions? Yes No

What is the highest level of education you have completed? 8th grade Some high school GED High school diploma Some college Associate degree Bachelor Degree Master degree Doctorate

Are you working? Yes Retired Looking for work Disabled Occupation: _____

Do you live alone or with others? Alone With others

Marital Status - Married Single Divorced Separated Widowed Domestic partner Unknown

Number of children: _____

On average, how many days per week do you engage in moderate to strenuous exercise? _____

Hobbies: _____

Sporting activities: _____

Caffeine intake: None Occasional Moderate Heavy

How often do you drink a drink containing alcohol? Never Monthly or less 2-4 times/month 2-3 times/week 4+ times per week

How many standard drinks containing alcohol do you have on a typical day? 1-2 3-4 5-6 7-9 10+

How often do you have 6 or more alcoholic drinks on one occasion? Never Less than monthly Monthly Weekly Daily/Almost daily

Illicit dugs: No Yes: _____

Prescription medication abuse: No Yes: _____

Environmental History:

Circle your answer(s) or fill in blanks.

Living situation: Single Family Home Townhouse Apartment (___ floor) Condo (___ floor) Dorm Trailer

Length of current living situation: Year you moved there- _____

Levels of living place: 1 2 3 4 5

Mold in house? Yes No

House foundation: Slab Crawl space Basement

Basement Finish: Finished Unfinished Partially Finished

Basement conditions/air quality: Ventilated Dry Musty Damp Seepage History of flooding Sump pump Dehumidifier

Basement flooring: Cement Carpet Tile Hardwood Ceramic Linoleum Other: _____

Heating system: Gas Oil Electric Pellet Stove Propane Wood burning fireplace Gas fireplace Electric fireplace Wood stove

Humidifier: None Stand alone Central

Heat delivery: Forced air Radiator

Air conditions type: None Central unit Window units Ceiling fans Window fans

Air filter type: Standard High efficiency allergy filter Electrostatic Electronic HEPA Other: _____

Bedroom floor level: 1 2 3 4 5

Bedroom flooring: Carpet Wood Tile Linoleum

Bed type: Air mattress Spring mattress Pillow top Foam Feather bed Futon Bunk bed Crib Water bed

Bed (mattress and boxspring) in allergy encasements? Yes No

Pillows in allergy encasements? Yes No

Bedroom ceiling fan? Yes No

Bedroom clutter? Yes No

Bedroom stuffed toys? Yes No

Pets in home? None Cat Dog Bird Reptile Small animal Horse Farm animals Exotic animal Other: _____

Specify the number of each pet type: _____

Pet sleeping arrangement: In bed In bedroom Outside bedroom Outdoors

Specify which pet(s) are in bed or bedroom: _____

Animal exposure outside of home? No Yes, please explain: _____

Occupational exposure history/health risks: _____

Significant travel history: No Yes, please explain: _____