Department of Allergy & Immunology

DR. _____

DATE OF APPT. _____

TIME _____

Dear Patient:

Please complete the enclosed questionnaire and bring it with you to the Clinic on the day of your appointment. If you have any questions, please feel free to contact us at (813) 974-2920.

Thank you

BP _____ Pulse _____
Weight _____ Height _____
(for medical staff completion)

ALLERGY, ASTHMA & IMMUNOLOGY
Roger V. Fox, M.D.
Dennis K. Ledford, M.D.
12901 Bruce B. Downs Boulevard
Tampa, Florida 33612 – 813-974-2596

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. You may use the back of each page to complete your answers.

NAME _____ **AGE** _____ **DATE** _____

Circle the allergy problems that you have:

(l) Hay fever/sinus
(2) Asthma/bronchitis
(3) Hives
(4) Eczema
(5) Insect allergy
(6) Food allergy
(7) Drug allergy
(8) Headache

I. CLINICAL HISTORY

A. Describe your major allergy symptoms. How do they make you feel?

_____
_____
_____

B. What are your expectations from this allergy consultation?

_____
_____
_____

II. SYMPTOMS (check)

Eye: Itching _____ Swelling _____ Burning _____ Tearing _____ Discharge _____

Ears: Itching _____ Fullness _____ Popping _____ Decreased Hearing _____ Pain _____

Nose: Sneezing _____ Itching _____ Runny nose _____ Mouth Breathing _____
Nasal obstruction _____ Discolored discharge _____ Snoring _____
Sense of smell impaired _____
Headache _____ Where? _____
How often? _____ How severe? _____

Throat: Itching _____ Soreness _____ Post nasal drip _____Throat clearing _____
Swelling _____

Chest: Cough _____ Sputum _____ Color and amount _____
Wheezing ____ Chest _____ Tightness ____ Shortness of breath with exercise _____
History of asthma diagnosed by physician _____
Exercise-induced asthma _____
Nighttime wheezing _____

Skin: Dermatitis ____ Eczema_____ Hives _____ Swelling _____ Rashes _____
Where on your body? _____

A. Age of onset of your respiratory allergies (hay fever and asthma)

B. Do you have daily symptoms? _____

C. Do you have seasonal symptoms? _____

D. Are you having more allergy problems recently? _____

E. What time of the year are your allergies worse? (Please list months.) _____

F. What time of day or night is the worst time according to you? _____

G. Does any particular exposure (cat, dust, smoke) make you much worse? (Please list.) _____

_____

H. Please list all food allergies. _____

History of milk allergy as an infant?

I. Please list all drug allergies. (Please list name of drug, type of reaction, and approximate date of reaction.)

_____

J. Have you had a life threatening allergic reaction to a stinging insect (bee, wasp, yellow jacket, hornet, fire ant)?

_____

K. Have you had hives previously? _____

L. Have you had eczema (atopic dermatitis as an infant or child) previously? _____

III. PREVIOUS ALLERGY EVALUATION AND TREATMENT

A. Name of allergist and city _____

B. Please list your allergies _____

C. Have you received allergy shots? _____

Were allergy shots beneficial? _____

How long were you on allergy shots? _____

D. Is your home environment allergy-free? _____

E. Please list all recent medications prescribed or over-the-counter drugs you have used to treat your allergies.

Antihistamines for allergies (Benadryl, Tavist, Trinalin, Seldane, Hismanal, Claritin, Semprex-D, and others):
improved _____ not improved _____ sedation _____

Bronchodilators for asthma - theophylline (Theo-Dur, Slo-Bid, Uniphyl) inhaled bronchodilators (Ventolin/Proventil, Maxair, Tornalate, Brethaire, Alupent, Serevent); and oral Ventolin/Proventil:
How often do you use? _____
improved _____ not improved _____ adverse reactions _____

Corticosteroids for hay fever or asthma - oral (prednisone); intranasal sprays (Vancenase, Beconase, Nasalide, Dexacort Turbinaire, Rhinocort intrabronchial (Vanceril, Beclovent, Aerobid, Azmacort):
How often do you use? _____
improved _____ not improved _____ adverse reactions _____

Last date on prednisone _____

Antibiotics for infections (sinusitis, bronchitis):
Name _____ How often do you use? _____
improved _____ not improved _____ adverse reactions (rash) _____

_____

Last date on antibiotics _____ Other treatment (Please list all medications that you take):

_____

IV. PAST MEDICAL HISTORY

A. Please list all important operations and other significant hospitalizations that you have had, even if they are unrelated to your allergy problem. _____

_____

B. Have you been hospitalized for asthma? _____ When? _____

Have you required emergency room visits or emergency treatment by your physician for asthma? _____

_____

C. Do you have any current medical problems or a history of any medical problems?
Diabetes _____ Thyroid disorder_____ High blood pressure_____ Seizures _____
Arthritis_____ Hepatitis _____ Ulcers _____ Other _____

D. Have you ever had a blood transfusion? _____ When? _____

E. Have you experienced recurrent sore throats, repeated sinus infections (how often?) _____
documented by x-ray? _____, or severe infections (what kind, kidney infection _____ ,
Meningitis _____ or pneumonia? _____), when?_____

F. Have you had nasal polyps, adverse reaction to aspirin, or sinus surgery? _____

G. Do you have any other symptoms or complaints (lack of energy, anxiety, or depression)? _____

H. Please list all your prescribed and over-the-counter medications (include aspirin, laxatives, sleeping medication).

_____

I. Have you had a chest x-ray, sinus x-ray, lung function tests, EKG, blood tests? Please comment on the results.

_____

J. Are your vaccinations up to date? _____ Tetanus? (every 10 years) _____

K. Do you receive the flu vaccine yearly? _____

L. Have you received the pneumovax (for pneumonia)? _____

V. REVIEW OF SYSTEMS

Do you have any of the following? (Check)

General
_____weight loss
_____chills
_____fevers
_____loss of appetite
_____dry mouth

Eyes and Ears
_____dry eyes
_____change in vision
_____Trouble hearing
_____ringing in ears

Skin
_____skin rashes
_____recurrent skin infections

Gastrointestinal
_____nausea
_____vomiting
_____diarrhea
_____change in bowel habits
_____trouble swallowing
_____heartburn

Cardiovascular
_____chest pain
_____chest pain with exercise
_____calf pain with exercise
_____ankle swelling

Kidney
_____trouble starting urine
_____bed wetting
_____burning with urination
_____loss of urine with cough or sneeze
_____frequent urination during the night

Blood
_____had anemia
_____bleed or bruise easily
_____swollen lymph nodes

Musculoskeletal
_____Morning joint stiffness and aching
_____painful, swollen joints
_____muscle tenderness or pain
_____muscle weakness

Endocrine
_____cold intolerance
_____heat intolerance
_____increased thirst
_____frequent urinations

Gynecological
_____excess bleeding
_____vaginal discharge
_____change in menstrual cycle

Neurological
_____weakness/clumsiness
_____tingling, burning, or numbness of extremities

Psychological
_____fearful, anxious
_____excessive worry
_____crying spells
_____trouble sleeping
_____behavior problems

Other
_____lumps or bumps under arms, breasts
_____skin rashes in the groin
_____skin rashes between legs
_____skin rashes on the toes
_____skin rashes on the feet

VI. ENVIRONMENTAL HISTORY

A. Do your symptoms occur around any specific environment, exposure, location, or activity (for example, lawn mowing, animals, dusty environments, old leaves, strong odors, exercise)? _____
B. Do you suspect that anything in your home, work place, or other locations cause your symptoms? _____
C. What type of home do you have and what is the surrounding area like (suburbs; country)? _____
D. Do you have indoor animals or birds? Please list. _____
E. Do you have a feather, foam, or Dacron-pillow? _____
F. Do you have a new or old mattress? _____ Or, a waterbed? _____
G. Do you have wall-to-wall carpeting throughout your home? _____

H. Are your windows opened or closed most of the time? _____

I. Do you have central air conditioning? _____

J. Does air conditioning help your symptoms? _____

K. Do your symptoms become better or worse on vacations, trips, or at the beach? _____

L. Do you have symptoms after eating at home or in a restaurant? _____

M. Does a change in the weather influence your allergic symptoms? _____

M. Do strong odors, powders, fumes, cigarette smoke make you worse? _____

N. How do strenuous activities affect your symptoms? _____

VII. PERSONAL AND SOCIAL HISTORY

A. Do you presently smoke (how much and how long)? _____

B. Have you ever smoked and when did you quit? _____

C. How much alcohol do you drink? _____

D. Do you use recreational drugs? (This is confidential.) _____

E. Do you consider yourself at risk for HIV? _____

F. What is your occupation? _____

What are your daily activities? _____

How many days have you missed from work or school? _____

G. Are you exposed to any toxic chemicals, noxious substances, or cigarette smoke? _____

H. How long have you lived in Tampa and/or Florida? _____

I. Where have you lived previously? _____

J. Are you happy with your life? If not, why? _____

K. How many other people live in your home? _____

Do any of them smoke? _____

VIII. FAMILY HISTORY

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

_____

_____

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

_____

_____