VIRGINIA ALLERGY & ASTHMA CENTER
NEW PATIENT QUESTIONAIRE

DATE: _____ Patient Name: _____ DOB: _____
What is the reason for your visit? _____
Referring MD_____ Primary MD: _____

SYMPTOMS: Circle if you have any of the following:

Nasal Congestion Runny/Itchy Nose Sneezing Loss of Sense of Smell

Dry Mouth Dry Eyes Itchy/Watery/Burning Eyes Coughing

Shortness Of Breath Wheezing Sinus Infections Facial Pressure/Pain

Post Nasal Drainage Hoarseness Throat Clearing Headaches Itching Skin

Skin Swelling Lip Swelling Painful Fingertips Upper Respiratory Infection

ALLERGY: Circle if you have any of the following:
Do you have allergies or hay fever? Yes No Seasonal
Have you ever been tested for allergies? Yes No What Type? Skin test OR Blood test
What Year: _____ Did you get allergy shots? Yes or No
How Long did you get shots? _____ What Year: _____ Did they help? Yes or No
Do you have any allergies to: Food Latex Insect Stings Dyes Antibiotics Injections

SINUS: Circle if you have any of the following
Do you have a history of sinus problems? Yes or No What? _____
What color is your nasal drainage today: _____
How many times have you been treated with an antibiotic for a sinus infection this year? _____
Have you ever had a sinus xray or CT? Yes No When and Where? _____
Have you ever had sinus/nasal surgery? Yes No If yes, When? _____ By who? _____
Was the surgery helpful? Yes or No

ASTHMA: Circle if you have any of the following
Have you ever been diagnosed with Asthma? Yes or No If yes, When? _____
Have you ever been to the ER because of Asthma? Yes or No How often? _____
Have you ever stayed in the hospital overnight for Asthma? Yes or No How often? _____
Have you ever missed work/school due to you Asthma? Yes or No How Often this year _____

REVIEW OF SYSTEMS: Please circle if you have had any of these in the *last 30 days*

Fever Weight change Fatigue Sleep problems Snoring Skin rash/Hives/Eczema

Unusual Bruising/Bleeding Heart Pounding/Palpitations Chest Pain Swollen Ankles

Dizziness Nausea/Vomiting Indigestion/Heartburn Constipation/Bloating Diarrhea

Trouble Swallowing Urinary Abnormalities Muscle pain/Aches/Cramps Joint Pain

Depression/Feeling Blue Anxiety/Feeling Nervous Hearing Problems Vision Problems

VIRGINIA ALLERGY & ASTHMA CENTER
NEW PATIENT QUESTIONAIRE

DATE: _____ Patient Name: _____ DOB: _____

GENERAL:
Have you ever had a chest x-ray or CT? Y or N If yes, when? _____ Results: _____
Have you ever had the pneumonia vaccine shot (Pneumovax)? Y or N If yes, when? _____
Do you get the flu shot each year? Y or N
How many times in the last year have you had to take oral or injectable steroids? _____
How many times this year did you seek ER care? ____ Were you hospitalized? _____ When? _____
How many times this year did you miss work/school for illness? _____

PAST MEDICAL HISTORY: Circle if you have a personal history of any of the following:

Hives Thyroid Disease Diabetes Pneumonia Tuberculosis Positive TB test

Frequent Bronchitis COPD/Emphysema Other Lung Condition Frequent Strep Throat

Frequent Sinusitis Sleep Apnea CPAP Machine Heart Arrhthmia/Palpatations Heart Disease

High Blood Pressure High Cholesterol Hepatitis/Liver Disease HIV/AIDS

Kidney Disease/Decreased Function Gynecological Problems Male Genital/Prostate Problems

Bowel/Intestinal Disorder Liver Condition Stomach Ulcer Acid Reflux Anemia/Low Blood Iron

Stroke/Mini Stroke Blood Disorder Cancer Neurological Condition Seizures/Epilepsy

Migraines Cataracts Glaucoma Arthritis Back/Spine Problems Osteoporosis

Depression/Sadness Panic Attacks/Anxiety Psychiatric Condition Alcoholism/Drug Dependency

FAMILY HISTORY:

Asthma:	__ Parent	__ Sibling	__ Child	__ Grandparent
Sinus Disease:	__ Parent	__ Sibling	__ Child	__ Grandparent
Hay Fever/Allergies:	__ Parent	__ Sibling	__ Child	__ Grandparent
Cystic Fibrosis:	__ Parent	__ Sibling	__ Child	__ Grandparent
Emphysema:	__ Parent	__ Sibling	__ Child	__ Grandparent
Thyroid Disease:	__ Parent	__ Sibling	__ Child	__ Grandparent
Heart Disease:	__ Parent	__ Sibling	__ Child	__ Grandparent
Diabetes:	__ Parent	__ Sibling	__ Child	__ Grandparent

Other: _____

SURGERY/HOSPITALIZATIONS: (List the type of surgery, reason for hospitalization and year)
_____

_____

_____

VIRGINIA ALLERGY & ASTHMA CENTER
NEW PATIENT QUESTIONAIRE

DATE: _____ Patient Name: _____ DOB: _____

SOCIAL HISTORY:

Occupation: _____ Company Name: _____

Hobbies: _____

Do you use tobacco products? Yes No In the Past What type: Cigarettes Cigar Pipe Snuff Dip

How much/many per day? _____ How many years? _____ When did you quit? _____

Have you ever been exposed to second hand smoke? _____ Where/When? _____

Do you use Alcohol? _____ Drinks per week? _____ Drug use? _____ What Drug? _____

Do you have HIV risk factors? ____

ENVIRONMENTAL HISTORY:

Do you live in an __ Apartment ___ Single Family Home

Is it in: __ the city __ the suburbs __ country

Who lives in the home? __ Spouse __ Significant Other __ Roommate __ Children __ Parents

Do you have pets at home? ____ What kind/how many? _____

Are they ___ indoor pets ___ outdoor pets ___ both Do they sleep in your bedroom? _____

Do your pets make your symptoms worse? ____ If yes, which pets specifically? _____

Has there been any water leaks/damage in your home? _____ If yes, was it repaired? _____

If yes, how was it repaired? _____

What types of flooring are in your home? ___ Carpet ___ Vinyl ___ Tile ___ Hardwood