Charles M. Fischman, M.D.

PATIENT (PARENT) QUESTIONNAIRE
ALLERGY

Patient's Name: _____ Birth Date: _____
Referring Physician: _____ Date Completed: _____

1. **MAJOR PROBLEM(S)** List: _____
_____
Date of onset: _____
In past year, problems are: _____ Worse _____ Unchanged _____ Better

2. **PAST MEDICAL HISTORY:**
Significant childhood illnesses: _____

Medical Problems: (Diabetes, Heart Disease, Kidney Disease, High Blood Pressure, Arthritis, Cancer, etc.) List: _____
_____

Hospitalizations: Reasons & Dates: _____
_____

Operations: _____ If yes, specify and give year: _____
_____

Serious Injuries (List injury and approximate date(s): _____
_____
_____

If patient is a child: Birth weight: _____ Breathing problem at birth? _____
As an infant, did patient have colic? _____ Eczema? _____ Many formula changes? _____
Constant runny nose? _____ Breathing problems? _____
Are immunizations complete? _____ Any adverse reactions to immunizations? _____

3. **PERSONAL HISTORY:**
List of Current Medications (Include dosage and frequency): _____
_____
_____

Are you allergic to any medications: _____ If yes, specify and describe reactions (include Aspirin): _____

Is patient in school? _____ Grade: _____ Name of School: _____
How many school days were missed last year because of illness? _____

Have you ever smoked cigarettes? _____ If yes, do you now smoke cigarettes? _____
How old were you when you first started regular cigarette smoking? _____
If you have stopped smoking cigarettes completely, how old were you when you stopped? _____
On the average of the entire time you smoked, how many cigarettes did you smoke per day? _____
Have you ever smoked cigars or a pipe regularly? _____
If yes, specify: _____
Are you exposed to secondary smoke? _____

Do you ever routinely use nose drops or nose spray? _____
If so, what kind? _____

Do you have problems eating certain foods? _____ If yes, specify and describe problems:
_____

4. **FAMILY HISTORY:**

Are your parents currently alive? _____ Mother _____ Father
Mother - Age if living: _____ Age at death: _____ Cause of death: _____
Father - Age if living: _____ Age at death?: _____ Cause of death: _____
Do you have any children? _____ If so, state age(s) and describe general health: _____

_____

FAMILY PROBLEMS: Check which ones and specify if: Parent-(F/M), Brother-(B), Sister-(S), Children-(CH), Grandparents-(GF/GM), Aunts-(A), Uncles-(U), Cousins-(C)

Asthma	_____	Bronchitis	_____	Nose Allergy	_____
Sinus Trouble	_____	Skin Allergies	_____	Emphysema	_____
Migraine Headaches	_____	Hives (Welts)	_____	Cystic Fibrosis	_____
High Blood Pressure	_____	Tuberculosis	_____	Repeated Infections	_____
Heart Disease	_____	Kidney Disease	_____	Cancer	_____
Diabetes	_____	Arthritis	_____	Other	_____

5. **OCCUPATIONAL HISTORY:**

A. Have you ever worked for a year or more in any dusty job? _____ Specify job, industry, total years of work and the amount of exposure: _____

B. Have you ever been exposed to gas or chemical fumes in your work? _____ Specify job, industry, total years worked and amount of exposure: _____

_____

C. What has been your usual occupation or job? _____

D. List your hobbies: _____

E. Do you feel your allergic complaints are related to your workplace? _____

If yes, 1. Do your complaints occur only at work? _____

2. Do complaints go away or improve at night, on weekends and on vacations? _____

6. **ALLERGIC HISTORY:**

Check any of the following symptoms that patient had or now has:

Nose/Throat:		**Chest:**		**Miscellaneous:**	
Frequent Colds	_____	Chronic Cough	_____	Tires Easily	_____
Chronic Congestion	_____	Shortness of Breath	_____	Poor Weight Gain	_____
Chronic Discharge	_____	Wheezing	_____	Fevers	_____
Chronic Sniffing	_____	Wheezing Attacks	_____	Bad Reaction to Insect Bites	_____
Frequent Sneezing	_____	Tightness in Chest	_____	Greasy, Fatty Stools	_____
Frequent Rubbing/ Itching	_____	Exercise Intolerance	_____	Irritable	_____
Frequent Sores	_____	Sputum or Phlegm	_____	Weight Loss	_____
Throats	_____	Pneumonia	_____	Night Sweats	_____
Polyps	_____	Bronchitis	_____	Bad Reaction to Insect Stings	_____
Sinus Problems	_____	Frequent Croup	_____		
Headaches	_____				

Skin:		**Ears:**		**Eyes:**	
Eczema	_____	Frequent Infections	_____	Redness	_____
Hives (Welts)	_____	Fluid	_____	Itching/Rubbing	_____
Dryness	_____	Hearing Loss	_____	Swelling	_____
Frequent Rashes	_____	Speech Problems	_____	Constant Circles	_____
Latex (Rubber Sensitivity)	_____				

Factors affecting Patient's Allergies/Problems. Base responses on your observations, not what you have been told by others:

	Better	Worse	No Change
Dec-Feb			
Mar-Apr			
May-June			
July-Nov			
Morning			
Afternoon			
Evening			
After Bedtime			
Inside House			
Outside House			
Running			
Biking			
Swimming			
Fatigue			
Tension			

	Better	Worse	No Change
Basement			
School			
Out of Town			
Dust			
Smoke			
Odors			
Cold Weather			
Damp Weather			
Wind			
Infection			
Weather Chng			
Cats			
Dogs			
Other Animals			
Grass/Mowing			

Check any of the following medicines or types of medicines you have used to treat your problem(s):

_____ Antihistamines (Actifed, Benadryl, Dimetapp, etc.)
_____ Nasal Sprays
_____ Alupent
_____ Bronchodilators (Aminophylline Theodur, Choledyl, Slobid, etc.)
_____ Brethine
_____ Breathing Treatments
_____ Adrenalin Shots
_____ Inhalers (Specify_____)
_____ Steroids (Prednisone, Cortisone)

Have you ever been allergy skin tested? _____
Have you ever had allergy shots? _____ If yes, did they help?_____ By whom? _____
When? _____ Findings: _____

7. **ENVIRONMENTAL HISTORY:**

What type of dwelling do you live in? _____ House _____ Apt _____ Trailer
How old is your dwelling? _____ How many years have you lived there? _____
Check those things below that apply to your home:

___ Dehumidifier
___ Air Purifier
___ Humidifier
___ Vaporizer Used
___ Central Air/Heat
___ Wall Unit
___ No A/C
___ Plants in Home
___ Pets (specify)
___ Smoking in Home
___ Cockroaches in Home

Do you routinely use Bounce Fabric Softener in your dryer? _____
Does patient share bedroom? _____ Sleep alone? _____ Sleep with someone? _____

Have you had any of the following tests? Indicate year and place done:
Chest X-ray: _____ TB Skin Test _____ Sweat Test: _____
Breathing Tests: _____ Sinus X-rays: _____

7. ENVIRONMENTAL HISTORY: (cont)

Check any of the following that are in patient's bedroom:

____	Curtains	____	Wool Blanket
____	Shades	____	Cotton Blanker
____	Blinds	____	Synthetic Blanket
____	Pets	____	Plastic Mattress Cover
____	Plants	____	Plastic Box Spring Cover
____	Air Vent	____	Feather Pillow
____	Air Conditioner	____	Foam Pillow
		____	Dacron Pillow

____	Stuff Toys	____	Linoleum Flooring
____	Stuffed Furniture	____	Wood Flooring
____	Shelves	____	Carpeting
____	Chalkboard		
____	Books		

8. REVIEW OF SYSTEMS:

		YES	NO
A)	**General:**		
	Do you usually feel persistently tired or worn out?	___	___
	Have you recently been drinking more water or fluids?	___	___
	Has there been any unusual weight gain or loss recently?	___	___
B)	**Cardiovascular:**		
	Do you have pain, tightness or pressure in the front or back of your chest?	___	___
	Have you been told your electrocardiogram was abnormal?	___	___
	Do you have any swelling of your feet or ankles?	___	___
	Does your heart ever beat fast or irregularly?	___	___
	Do you have cramps in the calf muscles when you walk?	___	___
	Do your fingers or toes ever get cold, become numb, or get very white or bluish?	___	___
C)	**Central Nervous System:**		
	Do you have frequent or severe headaches?	___	___
	Do you often have spells of dizziness, faintness or lightheadedness?	___	___
	Do you sometimes lose the ability to speak?	___	___
	Have you recently fainted, blacked out, lost consciousness?	___	___
	Do you have trouble remembering recent events?	___	___
	Do you ever have convulsions or fits?	___	___
D)	**Eyes:**		
	Have you had:		
	any pain in your eyes?	___	___
	glaucoma?	___	___
	blurry vision?	___	___
	halo around lights?	___	___
	change in vision?	___	___
	cataracts or implants?	___	___
	Do you wear glasses?	___	___
	When did you last see an eye doctor?	___	___
E)	**ENT:**		
	Do you have:		
	any trouble hearing?	___	___
	ringing or buzzing in your ears?	___	___
	earaches or discharge from your ear	___	___

		YES	NO
E)	**ENT:** (cont)		
	drainage down the back of your throat?	___	___
	frequent or severe nosebleeds?	___	___
	persistent hoarseness?	___	___
	bleeding gums?	___	___
	Do you use a hearing aid?	___	___
F)	**Gastrointestinal:**		
	Have you recently had any change in your eating habits?	___	___
	Have you recently noted any trouble in swallowing?	___	___
	Do you have a lot of indigestion or heartburn?	___	___
	Have you ever vomited blood?	___	___
	Are you bothered with constipation?	___	___
	Do you have frequent loose stools or diarrhea?	___	___
G)	**Skin:**		
	Do you have:		
	any change in the color of your skin?	___	___
	any rashes or itching?	___	___
	any growths or lumps on your skin?	___	___
	any sores or wounds that do not heal?	___	___
	any change in the color or size of warts or moles?	___	___
H)	**Genitourinary:**		
	Do you have:		
	burning or pain when you urinate?	___	___
	to pass water frequently?	___	___
	to get up at night?	___	___
	trouble with losing urine when you cough or sneeze?	___	___
	a problem with dribbling urine?	___	___
	Have you ever passed blood in your urine?	___	___
	Have you ever had an operation to prevent pregnancy? (Vasectomy or sterilization, such as tubal ligation)	___	___
	MEN: Do you have prostate gland trouble?	___	___
	Have you had herpes?	___	___
I)	**Musculoskeletal:**		
	Do you ever have a problem with back pain?	___	___
	Does back pain interfere with your work or activities?	___	___
	Do you have joint pain or stiffness (arthritis)?	___	___
	Do you have trouble walking or using your hip/knee joints?	___	___
J)	**Respiratory:**		
	Do you have:		
	frequent chest colds or pneumonia?	___	___
	a constant or bothersome cough?	___	___
	coughing of blood?	___	___
	difficulty breathing?	___	___
	wheezing or whistling in your chest?	___	___
K)	**Gynecologic (Women Only):**		
	Did you have any pregnancies?	___	___
	How many? _____		
	Have you had any lumps in your breast?	___	___
	Have you had any abnormal bleeding from the vagina in the past year?	___	___
	Have you passed the menopause or change?	___	___
	Do you have any prolapse ("falling out") of the vagina or uterus?	___	___
	Have you had a hysterectomy?	___	___
	Do you have any vaginal discharge?	___	___
	Have you had herpes?	___	___

		YES	NO
L)	**Psychiatric:**		
	Are you under psychiatric care?	___	___
	Have you ever been under psychiatric care?	___	___
	Do you hear voices?	___	___
	Have you ever wanted to commit suicide?	___	___
	Are you taking any antidepressants or other psychiatric medications?	___	___
M)	**Endocrine:**		
	Do you or have you ever had thyroid disease?	___	___
	Do you or have you ever had diabetes mellitus?	___	___
	Do you or have you ever had problems with excessive weight gain or loss?	___	___
	Have you ever seen an Endocrinologist?	___	___
N)	**Hematologic/Oncologic:**		
	Have you ever had skin cancer?	___	___
	Do you or have you ever had cancer other than skin cancer?	___	___
	Do you have excessive bleeding?	___	___
	Do you have a clotting disorder?	___	___
	Do you have swollen lymph glands?	___	___
	Do you take anticoagulants?	___	___
	Do you take aspirin or aspirin derivatives (anti-inflammatories) on a regular basis?	___	___
	Have you ever had a transfusion?	___	___
O)	**Allergic/Immunologic:**		
	Do you have hay fever?	___	___
	Do you have bronchial asthma?	___	___
	Do you have eczema?	___	___
	Do you have hives?	___	___
	Have you ever received gamma globulin injections?	___	___
	Have you ever been treated for an immunodeficiency?	___	___