DFW Allergist
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New Patient Questionnaire

Name: Date of Birth: Today's Date:

The following responses will help us to better evaluate you:

1. Your primary physician's name and city:
2. Your referring physician's name and city, or how did you find us:
3. Reason you are here today:
4. What do you want to accomplish at this visit?
5. What is your most bothersome symptom?
6. In terms of your symptoms, rank these seasons in order of BEST (1) to WORST (4):

   Spring ( ) Summer ( ) Fall ( ) Winter ( ) Or: My symptoms are the same all year long (YES/NO)
7. Are you ever symptom-free during the year? If so, when?
8. Are your symptoms better indoors, outdoors, or there is no difference?
9. Have you previously had allergy testing? When?
10. Have you previously had allergy shots or drops? When?
11. Have you ever used an albuterol inhaler or other inhaler? When was the most recent time?
12. Have you ever taken medication for heartburn or acid reflux? When was the most recent time?
13. How many courses of antibiotics have you taken in the past 365 days?
14. Have you ever been to the ER or urgent care? Most recent month/year?
15. Have you ever been hospitalized? Most recent month/year?
16. What surgeries have you had?

17. Have you ever been stung by an insect (such as a bee, wasp, hornet, or ant)? Did you only get symptoms only at the site of the sting, or did you also get symptoms elsewhere (e.g., hives all over, breathing problems)?
18. Have you ever had eczema or atopic dermatitis?
19. Which foods do you avoid and why?

20. Which medications or products do you avoid and why?

21. Do you have high blood pressure, an irregular heartbeat, diabetes, thyroid disease, or any problems with your heart, liver, or kidneys? What are your medical problems?

22. I have lived in the DFW area for _____ years. I moved here from:

23. What is your current job (or if in school, what grade):

24. Approximately how many days of work/school did you miss in the past 365 days? Why?

25. What indoor pets do you have?

26. What outdoor animals are you exposed to?

27. Do you have carpeting in the bedroom?

28. When was your current home constructed, approximately? When was your work/office built?

29. Has your home/work had water damage? Do you have any exposure to fungus, mold, mildew, or water damage where you live or work? Possible exposure to irritants or chemicals?

30. How much do you smoke?

31. How much do you drink?

32. Are you married? If so, for how long? Do you have children? What are their ages?

33. How many siblings do you have? What health problems do they have?

34. Which of your family members have allergies, asthma, or eczema?

35. What conditions run in your family? This includes children, siblings, parents, aunts, uncles.

36. Please list any medications you take for allergies, nasal symptoms, asthma, breathing symptoms:

37. Please list the medications you take every day:

38. Please list any other medications or supplements you take:

39. What are your hobbies and what do you do for fun?

40. What else is important for us to know?