CENTRAL TEXAS ALLERGY & ASTHMA

Priyanka Gupta, M.D.

UNDER 18

NEW PATIENT QUESTIONNAIRE (Please fill out completely)

Name:_____ DOB: _____ Sex: M F Age_____ Date:_____

Years in Central Texas: _____ How did you find out about this practice? _____

Referring Physician: _____ Ph.#:_____ Fax:_____

Private Physician: _____ Ph#:_____ Fax:_____

Preferred Pharmacy: _____ Ph#:_____

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT: (Include duration of symptoms)

_____

_____

_____

NASAL SYMPTOMS: Age when symptoms began or first noticed: _____

Over the past 12 months how often have you had: (circle response)

Congestion:	☐ Almost daily	☐ Seasonally	☐Rarely	☐Intermittently
Post Nasal Drainage:	☐ Almost daily	☐ Seasonally	☐Rarely	☐ Intermittently
Throat clearing:	☐Almost daily	☐Seasonally	☐Rarely	☐Intermittently
Runny Nose:	☐Almost daily	☐ Seasonally	☐ Rarely	☐ Intermittently
Sneezing:	☐Almost daily	☐Seasonally	☐ Rarely	☐ Intermittently
Itching:	☐Almost daily	☐Seasonally	☐Rarely	☐ Intermittently

Loss of Smell	☐ YES	☐ NO
Loss of taste	☐ YES	☐ NO
Bleeding	☐ YES	☐ NO
Snoring	☐ YES	☐ NO
sleep apnea	☐ YES	☐ NO

Triggers of your nasal symptoms?_____

ARE YOUR NASAL SYMPTOMS WORSE: Time of the year symptoms are the worst?

(*Check appropriate boxes*)

- ☐ Around strong odors
- ☐ With spicy foods
- ☐ Around dust
- ☐ In cold weather
- ☐ No seasonal change
- ☐ In high humidity
- ☐ With weather changes
- ☐ Air conditioning/drafts/wind
- ☐ Around smoke

- ☐ Feb – May
- ☐ June – Aug
- ☐ Sept – Nov
- ☐ Dec – Feb

ALLERGY HISTORY:

List dates and location of previous allergy tests: _____

Results: _____

List dates of previous allergy shots: Started: _____ Stopped: _____ ☐ Still getting

Did the shots help your allergies? ☐ Yes ☐ No ☐ Not Sure

Medicines taking for your allergies now: _____

Currently using Afrin/decongestant nasal sprays? ☐ Yes ☐ No If yes how often/how long? _____

Previously used medications for allergies: _____

EYES: ☐ Itching ☐ Burning ☐ Watery ☐ Redness ☐ Swelling ☐ Glaucoma ☐ Cataracts
Diagnosed with dry eyes? ☐ YES ☐ NO Do you wear contacts? ☐ YES ☐ NO

SINUS SYMPTOMS: (currently) ☐ Discolored drainage
☐ Pressure in cheeks ☐ Pain in cheeks ☐ Pressure around eyes **for** _____ days or weeks
Frequent sinus infections? ☐ Yes ☐ No If yes, how often? _____ per year
Have you had a sinus CT or X-ray? ☐ Yes ☐ No Date: _____ Results: _____
What was the last antibiotic you took? _____ When? _____
How many days? _____ Why did you take it? _____ Did it help? ☐ Completely ☐ Some ☐ None
Have you had surgery on your nose or sinuses? ☐ Yes ☐ No _____
History of sinus polyps? ☐ Yes ☐ No If yes, was surgery done/ when? _____

HEADACHES:
Sinus Frequency: _____ times per: week month year
Migraines Frequency: _____ times per: week month year
Stress Frequency: _____ times per: week month year
Headaches associated with? ☐ Nausea ☐ Vomiting Triggers: _____
Medicines for headaches or migraines: _____ Do they help? ☐ Yes ☐ No

EARS: ☐ Pain ☐ Itching ☐ Ringing ☐ Loss of Hearing ☐ Dizziness
Frequent infections requiring antibiotics? ☐ Yes ☐ No If yes, how often? _____ per/year
Have you had tonsil/adenoids removed? ☐ Yes ☐ No If yes, when? _____
Have you had PE tubes in your ears? ☐ Yes ☐ No If yes, when? _____
Have you seen a ENT? ☐ YES ☐ NO If yes who? _____

CHEST SYMPTOMS: Asthma / COPD Diagnosed? ☐ Yes ☐ No ☐ Both If yes, age diagnosed: _____

Cough:	Mild	Moderate	Severe	**and**	Daily	Weekly	Monthly	Seasonally	Intermittently
Wheeze:	Mild	Moderate	Sever	**and**	Daily	Weekly	Monthly	Seasonally	Intermittently
Tightness:	Mild	Moderate	Severe	**and**	Daily	Weekly	Monthly	Seasonally	Intermittently
Short of Breath	Mild	Moderate	Severe	**and**	Daily	Weekly	Monthly	Seasonally	Intermittently

List the medicines you **currently take** for asthma: _____
Have you ever taken Montelukast/Singulair? ☐ Yes or NO
List other asthma medicines or inhalers you have used **in the past**: _____
Have you received oral corticosteriods/steroid injections ☐ Yes ☐ No If yes, when? _____
Have you ever seen a Pulmonologist? ☐ Yes ☐ No Currently: ☐ Yes ☐ No If yes Dr: _____
With exercise do you have? ☐ Cough ☐ Wheeze ☐ Chest Tightness ☐ Shortness of Breath
Triggers: ☐Colds ☐ Bronchitis ☐ Allergy ☐ Exercise ☐ Laughter ☐Weather ☐Smoke ☐ Dust ☐ Animals
Cough triggered by laughter ☐ yes or ☐ no Cough is triggered by exercise ☐ yes or ☐no
Night Awakenings (due to breathing difficulty): _____ times/week _____ times/month
Have you had a chest X-ray/CT scan of the chest? ☐ Yes ☐ No Date: _____ Results: _____
Do you have a nebulizer (Breathing Machine)? ☐ Yes ☐ No How often do you use it? _____
Medications you use in nebulizer? _____
Do you have reflux symptoms? (heartburn, food coming back up, etc.) ☐ yes or ☐ no

Have you been to an Urgent Care/Texas Medical Clinic/ Emergency room for your asthma? ☐ Yes ☐ No Dates:_____

Have you ever had pneumonia? ☐ Yes ☐ No Dates: _____

Have you ever been hospitalized for your asthma? ☐ Yes ☐ No Dates: _____

Have you ever had RSV? ☐ Yes ☐ No Dates: _____

Have you ever been hospitalized for? ☐ Chest pain ☐ Palpitations ☐ Increased heart rate

Any smokers in your family/second hand smoke exposure? ☐ Yes ☐ No

SKIN:

Have you been diagnosed with eczema? ☐ Yes ☐ No

Do you have hives? ☐ Yes ☐ No

For how long? _____

Triggers: _____

Current skin medication: _____

Previous skin medication: _____

Have you seen a dermatologist? ☐ Yes ☐ No If yes, which one? _____

DIET HISTORY:

Do you have an Epi-Pen? ☐ Yes ☐ No

Do any foods cause a rash, cramping, diarrhea, itching or swelling of the mouth or throat, cough or wheezing, itchy skin, hives or headaches? List with type of reaction: _____

_____

VACCINATIONS

Are your vaccinations up to date? ☐ Yes ☐ No

Have you had the influenza vaccine? ☐ Yes ☐ No When? _____

Have you had the COVID vaccine? ☐ Yes ☐ No When? _____

6 YEARS AND UNDER CHILDREN ONLY:

Daycare? ☐ Yes ☐ No From what age and how often? _____

Breastfed? ☐ Yes ☐ No How Long? _____

Problems with formulas or foods? _____

Diagnosed with RSV? ☐ Yes ☐ No If yes, when _____

If born preterm /Premature, did the child receive the synagis vaccine? ☐ Yes ☐ No _____

FAMILY HISTORY: ☐ Unknown

	Father	Mother	Brother	Sister	Children	Grandparent
Asthma	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐
Hay Fever	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐

Other _____

List all medications you are taking and why you take them **(do not include allergy or asthma medications.)**

MEDICATION	DOSE	REASON FOR TAKING MEDICATION MEDICATION DIRECTIONS	APPROX. START DATE

SURGICAL HISTORY:

Have you had any surgery? ☐ Yes ☐ No_____

_____

ENVIRONMENT/SOCIAL:

What grade are you in? _____ Do you have siblings? ☐ Yes ☐ No If yes, How many siblings do you have?_____ Where were you born and raised? _____

Is your home in the ☐ Country ☐ Residential ☐ Rural / Residential ☐ Central AC

☐ Carpet in bedrooms? ☐Ceiling fan in bedroom ☐ Dust mite covers on pillows and mattress

Number of pets: Dogs _____ Cats _____ Birds _____ Other _____

Do pets come indoors? ☐ Yes ☐ No Do pets come in your bedroom? ☐ Yes ☐ No

Are your symptoms worse around the animals? Cat? ☐ Yes ☐ No Dog? ☐ Yes ☐ No Other ☐ Yes ☐ No

MEDICAL HISTORY:

Are you allergic to any medication(s)? ☐ Yes ☐ No

If yes, which medications: _____

Type of reaction: _____

If yes to penicillin, would you be interested in skin testing to verify this allergy? ☐ Yes ☐ No

Reaction to an insect sting? ☐ Yes ☐ No Type of insect if known: _____

What was the reaction, and when? _____