MIDWEST ALLERGY SINUS ASTHMA, SC

Dareen Siri, M.D .FAAAAI FACAAI, Dana Dalbak, PA-C, Megan Michael, PA-C
2010 Jacobssen Dr., Normal, IL 61761 ◎ (309) 452-0995
2151 W. White Oaks Dr., Springfield, IL 62704 ◎ (217) 717-4404
Outreach: Staunton, Carlinville
Fax: (309) 862-0961 ◎ Web: www.asthma2.com
Facebook: www.facebook.com/DrSiriMidwestAllergySinusAsthmaSC
Virtual Appointments: www.healthtap.com/dareensiri

Name _____DOB___/___/___ Age _____ Date _____

Primary Care Doctor _____ City_____ __ None

Referring Physician _____ City_____ __ Self-Refer

Insurance *Indicate PRIMARY with a "1" and SECONDARY with a "2"*
__Aetna __BCBS __BCBS HMO/PHAI __Cigna __Caterpillar __Coventry __Great West __Health Alliance HMO __Health Alliance PPO __HealthLink __Medicare __United Health
__Private Pay __Other_____

Pharmacy Information __30 Day Rx Preferred ___90 Day Rx Preferred
Usual Pharmacy_____Location_____
Mail-In Pharmacy_____Location/FAX_____

Drug Allergies __ None __ See my DRUG ALLERGY LIST
Please include name of drug, reaction, and date: _____
_____
Other Allergies __ None _____

Occupation_____ How long at this job?_____

Communication of Results *Our automated system will contact you by phone and e-mail, if both are provided, when your results have been reviewed (if applicable). A PIN number will be required in order to retrieve your results. You may also view all results at your leisure on the patient portal. Our staff will assist you in gaining access to the portal. Please provide:*

Preferred Phone _____ Preferred E-mail_____
May we leave information about your appointments/results on the phone/e-mail? __Yes __No

---

Please complete the following form. Please ask our staff if you have any questions or need help.

What problems are you having at this time?

_____

_____

How long have you had the problem? _____

How many times or is it ongoing? _____

What problems have you had in the past?

_____

_____

Does anything make the symptom better or worse, such as allergy triggers?

_____

_____

Expectations from this medical or allergy/asthma/immunology consultation?

____Allergy Testing _____

____Allergy Shots _____

RECENT MEDICAL EVALUATION:

Have you ever been evaluated by an allergist/immunologist? Yes____ No____

Doctor's Name:_____ City/State:_____ Date last seen:_____

Have you seen an ENT surgeon? Yes___ No____ Have you had sinus surgery? Yes____ No____

Have you had any blood tests to see if you have allergies? Yes____ No____

Have you ever been skin tested to evaluate allergies? Yes____ No____

What were you allergic to?

Trees___ Grass___Weeds___ Corn Pollen___ Cat___Dog___Dust Mites___ Dust___

Mold___Roach___Foods_____ Other_____

Have you ever been on allergy shots? Yes____ No____ Duration_____Last Shot_____

Were shots helpful? Yes____ No____ Not sure_____

Did you have any reactions? No____ Yes_____Describe:_____

Have you had any recent blood work? No___ Yes___ Date?_____ Where?_____

Have you had any recent X-rays? Sinus X-ray___ Chest X-ray___ Sinus CT___ Head CT___

Chest CT____ Other_____ Date?_____ Where?_____

What other doctors have you seen for the problem? *List name, type of doctor, date*

_____

Did you request records from another doctor sent here? No___ Yes___ Office?_____

MEDICATIONS ____See my MEDICINE LIST

List current medications or any changes/additions to your list, and reason for taking

1._____Reason:_____ 6._____Reason:_____

2._____Reason:_____ 7._____Reason:_____

3._____Reason:_____ 8._____Reason:_____

4._____Reason:_____ 9._____Reason:_____

5._____Reason:_____ 10._____Reason:_____

List over-the-counter (Tylenol, Aspirin), herbals, vitamins, medicated creams, and eye drops:

1._____Reason:_____ 5._____Reason:_____
2._____Reason:_____ 6._____Reason:_____
3._____Reason:_____ 7._____Reason:_____
4._____Reason:_____ 8._____Reason:_____

CURRENT MEDICAL PROBLEMS (Problem and date diagnosed)

1._____5. _____
2._____6. _____
3._____7. _____
4._____8. _____

Do you have any of the following?

Condition	No	Yes **	Not Sure	How long?	Severity/Comments
Allergy/Hay fever					**Mild__Moderate__Severe__**
Sinusitis					**Mild__Moderate__Severe__**
Eye Allergy					**Mild__Moderate__Severe__**
Asthma					**Mild__Moderate__Severe__**
Emphysema/ COPD					**Mild__Moderate__Severe__**
Lung Disease					**Mild__Moderate__Severe__**
Exercise-induced asthma					**Mild__Moderate__Severe__**
Hives/Urticaria					**Mild__Moderate__Severe__**
Swelling/ Angioedema					**Mild__Moderate__Severe__**
Rash/Eczema					**Mild__Moderate__Severe__**
Contact Dermatitis					**Mild__Moderate__Severe__**
Food Allergy					**Mild__Moderate__Severe__**
Drug Allergy					**Mild__Moderate__Severe__**
Insect Allergy					**Mild__Moderate__Severe__**
Vaccine Allergy					**Mild__Moderate__Severe__**
Anaphylaxis					**Mild__Moderate__Severe__**
Immune Problems					**Mild__Moderate__Severe__**

Headaches					**Mild__Moderate__Severe__**
Reflux/GERD					**Mild__Moderate__Severe__**
Autoimmune disease					**Mild__Moderate__Severe__**
Other (describe) _____					**Mild__Moderate__Severe__**

**Additional Questions

PAST MEDICAL and SURGERY HISTORY ___See my HEALTH HISTORY LIST

1._____ 5._____
2._____ 6._____
3._____ 7._____
4._____ 8._____

Blood Products: Have you ever had a transfusion/infusion? No___ Yes___ When?_____
Sex History: Are you concerned about STDs? No___ Yes___ Why?_____
Menstrual History: Regular__ Birth-control__ Post-Menopausal__ Hyst__ Irregular__ Problems__

Hospitalizations (Where, reason, date, and length of stay)

1._____ 3._____
2._____ 4._____

IMMUNIZATIONS ___See my SHOT RECORD

Are your immunizations up to date? Yes____ No____
Last Flu Shot _____ Never____ Last Tetanus Shot _____ Unsure____
Last Pneumovax / Prevnar (Pneumonia) Shot_____ Never____ Unsure____
Shingles Shot_____ Never____ Unsure____

FAMILY HISTORY

Immediate Family (Mother, Father, Siblings, Children):
Does anyone have asthma, hay fever, eczema, rash, food allergies, drug allergies, insect allergies, hives/angioedema, recurring and/or frequent infections? Please list and comment.

_____

Extended Family: List any relevant health or hereditary diseases that seem to occur frequently in your family (diabetes, emphysema, heart problems, thyroid, arthritis, autoimmune disease).

_____

ENVIRONMENTAL HISTORY:

Home: House____ Apartment____ Mobile Home____ Assisted-living____ Other_____
Age of Home:_____ Foundation: Basement___ Crawl-space___ Concrete___
Heat/cooling: Central____ Base-board____ Stove____ Radiator____ Window A/C___
Humidifier? Yes____ No____ HEPA filter? Yes____ No____
Do you keep your windows open or closed during nice weather? Open____ Closed___
Bedroom: Bed Age_____ Type: Synthetic____ Water____ Dust Mite Cover____

Pillow Age_____ Pillow Type: Synthetic____ Feather____ Dust Mite Cover____
Flooring in bedroom: Carpet____Age?_____ or Hard-surface____ Rugs_____
How many people live in the home: _____ Who lives with patient?_____
Is there a second parent's home or after-school care?_____
Are you exposed to smoke in the house? No____ Yes____ I smoke____ I don't smoke_____
Who smokes, if not you?_____ In the house?_____ In the car?_____
Do you ___Shower ___Bathe ___Daily ___Every other day ___Morning ___Evenings?

Frequent Animal Exposure: At my house_____ At someone else's house_____
Are the pets allowed inside the bedroom? Yes____ No____ Whose house?_____
Dogs___ Cats___ Rabbits___ Hamsters/Gerbils___ Ferrets___ Birds___ Horses___ Cattle___
Chickens___ Ducks___ Deer___ Roaches___ Ticks___ Fleas___ Mosquito___ Other_____

Are you exposed to any allergens or chemicals at work, doing hobbies, or at home? *List.*
_____
Do you wear any protection when working outdoors or at work? *List.*
_____

SOCIAL HISTORY
Years in Illinois: _____ Have you lived elsewhere?(Place/Time)_____
Exercise (times/week): _____ Type of exercise:_____
Seatbelt use: 100%___ Often___ Never___ Helmet use: 100%___ Often___ Never____
Sun exposure: Alot___ Some___ Rare___ Sunscreen : Frequently___ Rarely____
Tobacco: Is the patient exposed to "passive smoke" from a family member? Yes___ No___

Social History: (Adults and Adolescents)
Caffeine (drinks/day):_____ Type:_____
Tobacco: Never___ Yes___ Quit ___ Quit Date_____ Chew___ Vape___
Average packs per day?_____ How many years did you smoke?_____
Alcohol: Never___ Occas___ Daily___ Average drinks per week? ____ Type?_____
Recreational drugs: Never___ Yes___ Past ___ Type?_____

Social History: (If patient <12 years old)
School: Yes____ Homeschool_____ Preschool/Daycare_____None____ Grade:_____
Performance: Excellent___ Good___ Fair___ Poor___ Sports/Activities:_____

Birth History: (If patient <5 years old)
Birthplace (city/state):_____ Birth Weight:_____ Full term: Yes__ No__
Type of birth: Vaginal_____ C-Section ____ NICU stay?_____ Ventilator?_____
Breast fed: Yes___ No___ If "yes", for how long:_____
Formula type: Milk____ Soy___ Nutramigen___ Alimentum___ Elecare ____ Neocate_____
List problems with breastfeeding or formula:_____
Age started solid foods:_____ List problems with food/stool:_____

Additional Comments:

ADDITIONAL ALLERGY QUESTIONNAIRE: Rhinitis, Sinusitis, Chronic Sinusitis

---

Do you have daily symptoms: Yes ____No _____ Problems are: Year-Round____Seasonal ____
Timing: Worse than in Spring___ Summer____ Fall____ Winter____
Are your allergy symptoms: Getting worse____Getting better____ Constant____ Unchanged____
Check all allergy symptoms:

Eyes	Ears	Nose	Sinus /Head	Throat
___Itch ___Swelling ___Burning ___Pain ___Runny ___Watery ___Discharge ___Blurry vision ___Double vision ___Infections ___Other	___Itch ___Fullness ___Popping ___Decreased hearing ___Pain ___Feeling of fluid ___Infections ___Other	___Itch ___Sneezing ___Multiple sneezes ___Bleeding ___Stuffy nose ___Runny nose ___Clear discharge ___ Colored discharge ___Poor smell ___Mouth breathing ___Polyps ___Other	___Facial Pain ___Pressure ___Headache ___Dryness ___Concentration problems ___Sleep problems ___Fatigue ___Sinusitis ___Frequent infections ___ Other	__Itch __Drainage __Mucus __Burning __Pain __Swelling __Swallowing problems __Hoarse __Clearing __Clicking __Large glands __Infections __Cough __Bad taste __Acid taste __Bad breath __Other

Check all allergy triggers:

___Cats ___Dusting ___Indoors ___Smoke ___Being at Home
___Dogs ___Cleaning ___Outdoors ___Perfume ___Being at Work
___Horses ___Cold Air ___Eating ___Odors ___Mornings
___Grass ___Humidity ___Alcohol ___Being Hot ___Evenings
___Yardwork ___Wind ___Exercise ___Being Cold___Nighttime/Lying down
Foods (list):_____ Medication (list):_____ ___Other:

Have you ever been on "immunotherapy" for your symptoms? Yes____ No____ Uncertain____
____Allergy shots ____Sublingual allergy drops

Treatments you have tried: *Please check.*
Allergy pills: __Loratadine/Claritin/Alavert __Cetirizine/Zyrtec __Fexofenadine/Allegra __Benadryl __Hydroxyzine __Montelukast/Singulair __Zafirlukast/Accolate __Sudafed
Nose sprays: __Fluticasone/Flonase __Triamcinolone/Nasacort __Flunisolide __Nasonex __Beconase __Rhinocort __Veramyst __Omnaris __Qnasl __Zetonna __Dymista __Patanase __Azelastin (Astelin/Astepro) __Afrin __Vicks Spray __Mucinex __Wal-Four __Dristan
Saline: __Saline Spray __NettiPot __NeilmedRinse __NasalMist
Eyedrops: __Ketotifen(Alaway/Zaditor/Zyrtec or Claritin Eye Drops) __Patanol/Pataday __Pazeo __Bepreve __Azelastine/Optivar __Elestat __Opcon/Naphcon/Visine __Similasan

ADDITIONAL PULMONARY QUESTIONNAIRE: Asthma, COPD/Emphysema, Lung Problems

---

Onset of Symptoms (age): _____ Do you have daily symptoms: Yes ____No _____
Timing: Year-Round____Seasonal ____ Worse in Spring___ Summer____ Fall____ Winter_____
Is your breathing: Getting worse___ Getting better___ Constant____ Unchanged_____

Check all chest symptoms:

__Asthma __Emphysema/COPD
__Chronic Bronchitis __Bronchiectasis, Diagnosed when?_____
__History of Histoplasmosis, When?____ __Pulmonary hypertension
__History of Blood Clot/PE, When?____ __Other:_____
__Cough __Wheeze, Onset:_____ __Cough/Wheeze at Night, Onset:_____
__Cough/Wheeze with Activity __Cough/Wheeze with Laughing
__Chest tightness __Chest Pain __Shortness of Breath __Trouble with Activity
__Woken up by symptoms __Mucus production ___Clear ___Colored
__Frequent infections ___Pneumonia, How many times?_____ When?_____
___Bronchitis, How many times?_____When?_____

Check all triggers:

___Cats ___Yardwork ___Dusting ___Indoors ___Smoke ___Being at Home
___Dogs ___Wind ___Cleaning ___Outdoors ___Perfume ___Being at Work
___Horses ___Exercise ___Cold Air ___Eating ___Odors ___Mornings
___Grass ___Humidity ___Alcohol ___Being Hot ___Being Cold___Evenings
___Nighttime/Lying down Other:_____Foods (list):_____ Medication (list):_____

Have you had a chest X-ray? Yes__ No__ Chest CT? Yes__ No__ Date/result?_____
Have you had lung function testing? Yes___ No___ Date/results:_____
Have you ever been on a ventilator? Yes____ No____ Admitted to the ICU? Yes____ No____
How many times (lifetime) have you been on steroids:_____ Last course of steroids:_____
Have you had a Bone Density test? Yes____No____ Osteopenia/Osteoporosis? Yes____No____
Do you currently use “rescue medicine/albuterol”? Yes___ No___ Nebulizer___ Meter Inhaler____
times per week you use rescue?_____ Use of rescue at night Yes__ No__ # times?_____
Do you have smoke exposure? Yes___ No___ Do you have a wood burning stove? Yes___ No___
Have you been screened for Alpha-1 Antitrypsin Deficiency (genetic emphysema)? Yes___ No___
Would you like a complimentary screening today? Yes___ No___

Treatments you have tried: *Please check.*

Inhalers: __Flovent __Pulmicort __Asmanex __Qvar __Alvesco __Aerospan __Arnuity __Advair
__Dulera __Symbicort __Breo __Foradil __Serevent __Stiverdi __Spiriva __Tudorza __Anoro
__Combivent __Albuterol __Xopenex

Nebulizers: __Brovana __Performist __Budesonide (Pulmicort) __Albuterol __Xopenex
__Duoneb __Ipatroprium (Atrovent) __N-Acetylcysteine

Pills: __Singulair __Accolate __Theophylline __Daliresp __Mucinex __Pulmozyme

Other: __Xolair __Oxygen __CPAP __Pulmonary Rehab List:_____

Did they help your breathing? Yes___ No___ Uncertain___ What was most effective?_____

Please answer if you have or your child has ASTHMA:

Do you use a peak flow meter? Yes____ No____ Best peak flow (liters/min):_____

Do you have an Asthma Action Plan? Yes___ No____

Do you want more information about a peak flow meter / Asthma Action Plan? Yes___ No___

ASTHMA CONTROL TEST (12 years and up) *Score <19 suggests that Asthma needs addressed.*

In the past 4 weeks, how much did your asthma keep you from getting as much done at work, school or home?

1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

During the past 4 weeks, how often have you had shortness of breath?

1. More than once a day 2. Once a day 3. 3-6 times a week 4. 1-2 times a week 5. Not at all

During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

1. 4 or more nights a week 2. 2-3 nights a week 3. Once a week 4. Once or twice 5. Not at all

During the past 4 weeks, how often have you used your rescue inhaler or neb (such as albuterol)?

1. 3 or more times per day 2. 1-2 times per day 3. 2-3 times per week 4. Once a week or less 5. Not at all

How would you rate your asthma control during the past 4 weeks?

1. Not Controlled 2. Poorly Controlled 3. Somewhat Controlled 4. Well Controlled 5. Completely Controlled

ASTHMA CONTROL TEST (4-11 years) *Score <19 suggests that Asthma needs addressed.*

How is your asthma today? 0. Very bad 1. Bad 2. Good 3. Very good

How much of a problem is your asthma when you run, exercise or play sports?

0. It's a big problem, I can't do what I want to do. 1. It's a problem and I don't like it.
2. It's a little problem but it's okay. 3. It's not a problem.

Do you cough because of your asthma?

0. Yes, all of the time. 1. Yes, most of the time. 2. Yes, some of the time. 3. No, none of the time.

Do you wake up during the night because of your asthma?

0. Yes, all of the time. 1. Yes, most of the time. 2. Yes, some of the time. 3. No, none of the time.

During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5. Not at all 4. 1-3 days 3. 4-10 days 2. 11-18 days 1. 19-24 days 0. Everyday

During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5. Not at all 4. 1-3 days 3. 4-10 days 2. 11-18 days 1. 19-24 days 0. Everyday

During the last 4 weeks, how many days did your child wake up during the night due to asthma?

5. Not at all 4. 1-3 days 3. 4-10 days 2. 11-18 days 1. 19-24 days 0. Everyday

Please answer below for Sleep Apnea Screening.

0 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Sitting and reading _____

Watching TV _____

Sitting inactive in a public place (e.g a theater or a meeting) _____

As a passenger in a car for an hour without a break _____

Lying down to rest in the afternoon when circumstances permit _____

Sitting and talking to someone _____

Sitting quietly after a lunch without alcohol _____

In a car, while stopped for a few minutes in traffic _____

ADDITIONAL SKIN QUESTIONNAIRE: Eczema, Hives, Swelling/Angioedema, Itch, Rash

---

When did your rash first start?_____ Age at onset? _____
Where do you have the rash? _____Where did it first appear?_____
Do you have daily symptoms? Yes ____ No _____ Timing: Year-Round____Seasonal ____
Have you had the rash before? Yes ____ No _____ Spring___Summer___Fall___Winter___
Is your skin/rash: Worse___ Better___ Constant____Comes & Goes___ Unchanged____
Do you have a dermatologist? Yes____ No____ Name:_____

What do you think causes your rash?_____
What size are the individual rash spots?_____
Is there any pattern that your rash follows? (Describe)_____
The rash is (describe):_____

ITCHES: Yes ____ No____ Uncertain____
BRUISES: Yes ____ No____ Uncertain____ Spontaneously____ After scratching____
PAINFUL: Yes ____ No____ Uncertain____
FEATURES: Flat____ Raised____ Blistered____ With Swelling____ Red____ Purple____
Other_____
DURATION: Minutes to Hours_____ Hours to Days_____ Weeks_____ Months____
WORSE: In the AM____ In the PM____ At Night____ No Change Day or Night____
After Eating____ Which foods?_____
After Drinking Alcohol_____ Which?_____
Around Pets____ Which?_____
After Exercise____After Sweating___ After Hot Showers____ With Sun____
During Cold Weather____ After Being Cold____ After Swimming____
After Yardwork____ After Housework____
Outdoors___ Indoors____ Home___ Work___ School___ Vacation___
With Stroking/Rubbing____ With Tight Clothing____ With Vibration____
With Emotional Stress_____ Other_____

Have you had:

Skin Infection / Antibiotics / Anti-fungal? Yes____ No____ Which/When?_____
Skin Biopsy? Yes____ No____ Results:_____
Skin Sensitivity? Fragrance____Metals____Sulfates____Parabens____Formaldehyde____
Wool___Latex___Rubber___Adhesive___Neomycin___Benzalk____Other_____
Travel Abroad just before the rash started? Yes____ No____ Where/When?_____
New Medicines just before the rash started? Yes____ No____ Which/When?_____
Discontinuation of any medicines? No___ Yes___ Which?_____ How long?_____

Have you been evaluated for food allergy? Yes____ No____ Which/When?_____
Have you had any of the following symptoms associated with your rash?

Excessive sweating___ Diarrhea___ Headaches___ Abdominal cramps___ Fever___
Muscle pains___ Joint swelling___ Joint pain/stiffness___ Fatigue___ Other_____

What other skin conditions have you had? List:_____

Eczema / Atopic Dermatitis____ Diagnosed when?_____ Contact Dermatitis___
Hives / Angioedema___ Seborrheic Dermatitis___ Vitiligo___ Alopecia___ Lupus___

ADDITIONAL SKIN QUESTIONNAIRE (Page 2)

Skin Care

What medications have you used to control your rash?

ORAL STEROIDS No___ Yes___ How many times?_____ When?_____

1._____ Effective____ Not effective____ Currently Using___

2._____ Effective____ Not effective____ Currently Using___

ORAL IMMUNOSUPPRESSANTS No___ Yes___ When?_____

1._____ Effective____ Not effective____ Currently Using___

2._____ Effective____ Not effective____ Currently Using___

TOPICAL MEDICATED CREAMS No___ Yes___

1._____ Effective____ Not effective____ Currently Using___

2._____ Effective____ Not effective____ Currently Using___

3._____ Effective____ Not effective____ Currently Using___

4._____ Effective____ Not effective____ Currently Using___

ORAL ANTI-HISTAMINES / ANTI-ITCH No___ Yes___

1._____ Effective____ Not effective____ Currently Using___

2._____ Effective____ Not effective____ Currently Using___

3._____ Effective____ Not effective____ Currently Using___

4._____ Effective____ Not effective____ Currently Using___

MOISTURIZERS? No___ Yes___

1._____ Effective____ Not effective____ Currently Using___

2._____ Effective____ Not effective____ Currently Using___

3._____ Effective____ Not effective____ Currently Using___

4._____ Effective____ Not effective____ Currently Using___

List if Applicable:

Shampoo_____Conditioner_____

Soap_____ Body Wash_____

Bubble Bath_____ Diaper_____

Dish Soap_____ Rinsing Agent_____

Laundry Soap_____ Fabric Softener_____

Make-up_____ After-Shave_____

Deodorant_____ Fragrance/Cologne_____

Soap At Work_____ Air Fresheners_____

Other Chemical Exposures_____

Hobbies that might exposure you to chemicals or allergens (electronics, construction, jewelry, etc):

_____

ADDITIONAL QUESTIONNAIRE: Food allergy and digestive problems

---

Onset of Symptoms (age): _____ Do you have daily symptoms: Yes ____No _____

If you are an adult, did you have food allergies as a child? Yes__ No__ Unsure__

Do you have Eosinophilic Esophagitis? Yes__ No__ Unsure__

Do you have Food-Induced Eczema? Yes__ No__ Unsure__

Do you have Food-Induced Allergy/Congestion/Asthma? Yes__ No__ Unsure__

Timing: Year-Round____Seasonal ____ Worse in Spring___ Summer____ Fall____ Winter

Are your problems: Getting worse___ Getting better___ Constant____ Past____

Food Allergy:

Symptoms associated:

Skin	Hives__ Swelling__ Rash__ Eczema__
Head/Mouth	Runny Nose__Itchy Eyes__ Congestion__ Throat Clearing__ Tongue Swelling__ Mouth Sores__ Mouth/Throat Itchy__ Headache__ Fogginess__ Poor Concentration__ Hyperactive__ Sleepy/Tired__
Breathing	Chest Tightness__ Cough__ Wheezing__ Aspiration__
Vascular	Dizziness__ Fainting__ Low Blood Pressure__ Heart Racing__
GI	Nausea__ Vomiting__ Acid Reflux__ Diarrhea__ Constipation__ Bloating__ Belching__ Flatulence__ Abdominal Pain/Cramping__ Choking__ Food Getting Stuck__ Pain on Swallowing__ Slow-eater__ Slow-Chewer__
Joints	Joint Swelling__ Joint Pain__ Extremity Swelling__

Suspected Food: _____ Date/Age:_____ Reaction:_____

Suspected Food: _____ Date/Age:_____ Reaction:_____

Suspected Food: _____ Date/Age:_____ Reaction:_____

I have a diagnosed food allergy. Yes__ No__ Diagnosed when?_____

How? Blood Test__ Skin Test__ Other _____ By Who?_____

1. Food: _____ Date/Age:_____ Reaction:_____
2. Food: _____ Date/Age:_____ Reaction:_____
3. Food: _____ Date/Age:_____ Reaction:_____
4. Food: _____ Date/Age:_____ Reaction:_____

Do you/your child have a Food Anaphylaxis Action Plan? Yes___ No___ Need one? Yes__ No__

Do you have emergency EPINEPHRINE (EpiPen, EpiPen Jr, AuviQ, Adrenaclick)? Yes___ No___

Have you ever used or received epinephrine? Yes____ No____ When?_____

Have you ever visited the ER for an allergic reaction? Yes____ No____ When?_____

Have you ever been hospitalized for an allergic reaction? Yes____ No____ When?_____

Are you taking a BETA BLOCKER or ACE-INHIBITOR category of medicine?

Yes____ No____ (These types of medicines sometimes interfere with Epinephrine).

ADDITIONAL QUESTIONNAIRE: Drug / Insect / Vaccine and Other Allergy problems

---

Onset of Symptoms (age): _____ Do you have daily symptoms: Yes ____No _____
Timing: Year-Round____Seasonal ____ Worse in Spring___ Summer____ Fall____ Winter
Are your problems: Getting worse___ Getting better___ Constant____ Past____

Tell Us About the Problem:

_____

_____

Drug Allergy: (Include Vaccines, Anaesthetics, Contrast Dye)

Do you have an Aspirin allergy? Yes__ No__ Unsure__
Do you have a Nonsteroidal Agent (NSAID) allergy? Yes__ No__ Unsure__

1. Drug: _____ Date/Age:_____ Reaction:_____
2. Drug: _____ Date/Age:_____ Reaction:_____
3. Drug: _____ Date/Age:_____ Reaction:_____
4. Drug: _____ Date/Age:_____ Reaction:_____
5. Drug: _____ Date/Age:_____ Reaction:_____
6. Drug: _____ Date/Age:_____ Reaction:_____
7. Drug: _____ Date/Age:_____ Reaction:_____
8. Drug: _____ Date/Age:_____ Reaction:_____
9. Drug: _____ Date/Age:_____ Reaction:_____
10. Drug: _____ Date/Age:_____ Reaction:_____

Insect Allergy:

Have you ever had a large or “life threatening” reaction to a stinging insect? Yes_____ No_____
Date_____ Suspected insect_____ Reaction_____

Do you have emergency EPINEPHRINE (EpiPen, EpiPen Jr, AuviQ, Adrenaclick)? Yes___ No___
Have you ever used or received epinephrine? Yes____ No____ When?_____
Have you ever visited the ER for an allergic reaction? Yes____ No____ When?_____
Have you ever been hospitalized for an allergic reaction? Yes____ No____ When?_____
Are you taking a BETA BLOCKER or ACE-INHIBITOR category of medicine?
Yes____ No____ (These types of medicines sometimes interfere with Epinephrine).

ADDITIONAL QUESTIONNAIRE: Immune problems

Onset of Symptoms (age): _____ Do you have daily symptoms: Yes ____No _____
Timing: Year-Round____Seasonal ____ Worse in Spring___ Summer____ Fall____ Winter
Are your problems: Getting worse___ Getting better___ Constant____ Past____

Immunology Evaluation:

Have you ever been diagnosed with a primary immunodeficiency? No___ Yes___
Describe: _____
Have any family members ever been diagnosed with an immunodeficiency? No___ Yes___
Describe: _____
Have you ever been diagnosed with any of the following:
Pneumonia___ Meningitis___ Osteomyelitis___ Sepsis___ Recurrent UTI___
Bronchiectasis___ Chronic Bronchitis
Neutropenia___ Low Platelets____ Recurrent Pharyngitis___
Persistent Lymph Nodes/Swollen Glands___ Delayed Umbilical Cord Separation___
Severe Skin Infection___ Abscesses___
Cystic Fibrosis___ Complement deficiency___ IgA deficiency___ HIV___ AIDS___
Antibody deficiency___ Common Variable Immunodeficiency___ Other: _____

How many times have you had pneumonia? _____ How many per year? _____
How many sinus infections have you had in your life? _____ How many per year? _____
How many ear infections have you had in your life? _____ How many per year? _____
How many throat infections have you had in your life? _____ How many per year? _____
Have you ever been evaluated for primary immunodeficiency? Yes____ No____
Have you ever been tested for HIV? Yes___ No___ If “yes”, last date and result:_____
Have you ever received intravenous immunoglobulin (IVIG) or subcutaneous IG?
Have you ever received allergy shots or allergy drops? (Known as subcutaneous immunotherapy, SCIT, or sublingual immunotherapy, known as SLIT)? No___ Yes____
Describe: _____