DESERT CENTER FOR ALLERGY AND CHEST DISEASES

Pulmonary Medicine, Allergy/Immunology, Sleep Disorders

Pulmonary Rehabilitation, Pulmonary Function Laboratory

PEDIATRIC/ADULT ALLERGY, ASTHMA & IMMUNOLOGY HEALTH QUESTIONAIRE

Legal Name: _____

Preferred Name: _____

Parent/Guardian Name (If applicable): _____

To Which Does Patient Most Identify:

Female | Male | Transgender Female | Transgender Male | Gender Variant/Nonconforming

Not Listed | Prefer not to answer

Patient's Primary Care Provider is: _____

What is/are your presenting problem(s)?		
How long has it been going on?		
Any of following symptoms? ***(Circle if Yes)***	Nasal Congestion | Nasal Stuffiness | Runny Nose | Postnasal Drip| Sneezing | Itchy Eyes | Watery Eyes | Sinus Pain/Pressure | Poor Sense of Smell | Wheezing | Cough | Shortness of Breath | Chest Pressure/Pain with Exertion | Heartburn | Hoarseness | Difficulty Swallowing | Hives/Welts | Eczema/Skin Patch | Anaphylaxis	
List any medications/therapies related to this problem	<u>Name of Med/Therapy</u>	<u>Helpful or not?</u>

PAST MEDICAL HISTORY (Applies to patient)

******Do not leave blank******

Asthma	Y | N	**Immunodeficiency**	Y | N	**Diabetes**	Y | N
Seasonal Allergies	Y | N	**Food Allergies**	Y | N	**High Blood Pressure**	Y | N
Eczema	Y | N	**Bee/Insect Sting Allergy**	Y | N		
Others (Please List):					

SOCIAL HISTORY

******The following survey helps identify social factors for allergy evaluation. <u>Do Not leave blank</u>******

1. **Has patient ever smoked? ___**
    a. **If yes** *(If no, skip to question 2)*
        i. **What age began? ___ What age quit? ___**
        ii. **Or, Active Smoker? ___**
        iii. **How many packs a day? ___**
2. **Does patient consume alcohol? ___**
    a. **How often? _____** *(If not, skip to question 3)*
    b. **How many? _____**
3. **Type of Home:** Free Standing | Apartment/Condo | Mobile Home | Other
4. **Type of floor in patient bedroom:** Carpet | Tile | Wood | Other
5. **Type Of Air Conditioning:** Central | Swamp Cooler | Window Unit(s) | None
6. **Air Filtering System in Home:** Part of A/C System | Free Standing Unit(s) | None
7. **Humidifier Use in Home:** Yes | No | Sometimes
8. **Farm Animal Exposure:** No exposure |Located on Property | Located within 2-3 mile radius of home | Occasional Exposure only | Which animals? _____
9. **Home smoke exposure?** Indoor Smoking | Others Smoke Outdoors | None
10. **Pets in home or animals at work?** Yes | No
    a. **What type(s): _____** *(If no, skip to Question 11)*
    b. **Pet(s) enter patient's bedroom?** Yes | No
11. **Any exposure in home (or worksite) with Pest/insects/rodents?** Yes | No
12. **Is patient employed and/or in School?** Yes | No **Retired?** Yes | No
    a. **Job Type or Student: _____** *(If no, skip to question 13)*
    b. **Location (circle more than one if nec):** Home | Office | Outdoor | School
13. **How long has patient lived in Arizona? _____**

MEDICATION ALLERGIES: List medications/drugs you have allergy to:

If none write "n/a"

SURGICAL HISTORY:

*****Attention to sinus, ear, or nasal related procedures*****

		Date(s)
Tonsils/Adenoids Removed?	**Y | N**	
Sinus Surgery:	**Y | N**	
Others:		

FAMILY HISTORY: What illnesses are seen in patient's family? *(DO NOT LEAVE BLANK)*

****Special Attention to Asthma, Environmental Allergies, Food Allergies, Eczema, Immunodeficiency*****

Unknown | Adopted

	Condition
Mother	
Father	
Sibling(s)	
Grandparent(s)	
Child(ren)	
Other(s)	

MEDICATIONS/DRUGS

******Please list all including prescriptions,nasal sprays, over-the counter, and vitamins/herbs******

Medication Name	**Dose**	**How Often?** **Daily (Routine Use) or As-Needed Only)**

VACCINATION HISTORY

1. **Is patient up to date on routine vaccinations:** Yes | No
2. **Approx Date of Last Influenza Vaccine *(Leave Blank if unvaccinated):* _____**
3. **Approx Date of Last COVID-19 Vaccine: *(Leave Blank if unvaccinated):* _____**
4. **Approx Date of Last Pneumonia vaccine: *(Leave Blank if unvaccinated):***
    a. **PNEUMOVAX (PPSV23) ____**
    b. **PREVNAR(PPV13) ____**
    c. **PCV15 ____**
    d. **PCV20 ____**

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