



Allergy, Asthma & Immunology Associates, P.C.

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Asthma & Allergy Questionnaire

Patient Name: _____

Today's Date: _____

Date of Birth: _____

Referring MD: _____

1. What is your major problem(s) / chief complaint which brought you here? _____

2. What upper respiratory symptom(s) bothers you the most? (Lung symptoms see p. 3)

- | | | | |
|--|-------------------------------------|--|-----------------------------------|
| <input type="checkbox"/> Nasal/Sinus Congestion | <input type="checkbox"/> Runny Nose | <input type="checkbox"/> Itchy, watery eyes | <input type="checkbox"/> Headache |
| <input type="checkbox"/> Sinus pain and pressure | <input type="checkbox"/> Drainage | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Ear Pressure / Fluid | <input type="checkbox"/> Sneezing | <input type="checkbox"/> Sore Throat | <input type="checkbox"/> _____ |

3. How long have you had these symptoms? _____ weeks _____ months _____ years

Are your allergy symptoms getting worse? Yes No

4. Are there any factors which make your symptoms worse?

- Exposure to Dust Dampness Time of Day Season
 Activities Pollen Animals
 Irritants Foods Medicines
 Other: _____

5. Are there any factors which make your symptoms better?

Exposure to Time of year Air Conditioning Medications

6. What medications are you now taking? Name, Dose and Frequency.

_____	_____
_____	_____
_____	_____
_____	_____

7. What medicines have you taken in the last month?

_____	_____
_____	_____
_____	_____

8. Have any medications been helpful?

9. Which have not helped or made things worse?

10. Do you have any other health problems we should know about?

Heart Lung Gastrointestinal Kidneys
 Neurological Muscular / Skeletal Genitourinary tract
 Skin Kidneys Other: _____

11. Have you ever been hospitalized or gone to the ER / Urgent Care? Yes No
or had any operations? Yes No

If yes, explain: _____

12. Do you have other family members, relatives with allergy, asthma, sinus or other chronic respiratory problems?

Mother Father Brother Sister
 Aunt Uncle Grandparents Children _____

13. Are there any other health problems which tend to run in your family?

Heart Diabetes Kidney Infections Arthritis
 High Blood Pressure Cancer Other _____

14. Social Environment (including Daycare, School, Work)

Age of House _____ years Work / School _____ years

Type of heating / cooling at home _____

Carpets Tile Wood floors

Number of bedrooms _____ Location _____

Kitchen / Living room _____

Cigarette Smoke? Yes No _____

Animals exposure? Where? Yes No _____

Plants? Yes No _____

Irritants? Yes No _____

Dampness? Yes No _____

15. Any allergies to medications? Yes _____ No

Allergies to vaccines? Yes _____ No

16. Have you had allergy testing before? Yes No

If yes, where were you tested and when? _____

If yes, what allergens were positive? Weeds Trees Grasses Molds
 Animals Foods Medicines Other _____

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If Patient has **ASTHMA / CHRONIC RESPIRATORY DISEASE**, proceed with the following questions:

17. How long have you had asthma or asthma symptoms? \_\_\_ weeks \_\_\_ months \_\_\_ years  
Is it getting worse?  Yes  No

15. Describe symptoms:

Wheezing  Shortness of Breath  Chest tightness  Chest pains  
 Coughing  Night Coughing  Other: \_\_\_\_\_  
 Coughing with Irritants  Cold Air  Exercise  Laughing  
 Viruses  Other: \_\_\_\_\_

18. Do you have symptoms more than once a week?  Yes  No

19. Have you been:  hospitalized  gone to the Emergency Room  
 had to see a doctor for your asthma?

20. What medications have you taken in the last month for your asthma?

Advair  Albuterol  Nebulizer  Singulair  \_\_\_\_\_  
 Qvar  Proventil  Asmanex  Theophylline  \_\_\_\_\_  
 Prednisone  Combivent  Flovent  \_\_\_\_\_  \_\_\_\_\_  
 Medrol dosepak  Xopenex  Pulmicort  \_\_\_\_\_

21. Are there any asthma medications you cannot take? \_\_\_\_\_  
\_\_\_\_\_

22. Describe factors which might make your asthma worse. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

23. Have you had frequent infections in the last 5 years?  Yes  No

24. Have you taken antibiotics frequently in the last 5 years?  Yes  No

25. Have you missed any work or school due to asthma in the last 3 years?  Yes  No  
\_\_\_\_\_ days \_\_\_\_\_ weeks \_\_\_\_\_ months \_\_\_\_\_ years