**Hinsdale Asthma and Allergy Center**

**Initial Visit Patient Questionnaire**

Please bring this completed form with you to the appointment. Please do not mail this form to the clinic.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_

Patient’s primary care provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Who referred you to this clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Reason for this visit:**

Please provide a very brief description of the reason(s) for this visit. The medical provider will review this in further detail during the appointment. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Past Medical History:** (please circle the appropriate *italicized* answer when possible)

For pediatric patients:

Was your child born within two weeks of the expected due date (full term)? *Yes No*

If your child was born early, (preterm) how many weeks early was he/she born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much did your child weigh at birth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did the mother or child have any problems with the pregnancy, delivery or newborn period? *Yes No*

If yes, what problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

For all patients:

Were you adopted? *Yes No*

Does you have any recurrent or long term medical problems? *Yes No*

If yes, please specify: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been admitted to a hospital or had an overnight hospital stay? *Yes No*

If yes, for what reasons? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been admitted to the Intensive Care Unit (ICU)? *Yes No*

Have you ever required intubation (breathing tube) or mechanical ventilation? *Yes No*

Have you had any surgery? *Yes No*

If yes, what type of surgery and when did this occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had medical imaging (such as chest x-ray, CT scan)? *Yes No*

If yes, what imaging and when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immunizations:**

Are your immunizations (vaccinations) up to date? *Yes No*

Have you received the influenza (flu) immunization this year? *Yes No*

**Medicines:** (list name, dosage and frequency of use)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Allergies:**

Do you have any allergies or side effects to medicines, foods or with latex exposure? *Yes No*.

If yes, please state which medicine, food or latex product and describe the reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Family History:**

Please check the box (□) for any illnesses that occur in the family (mother, father, brother, sister, maternal and paternal grandparents, aunts, uncles, cousins). Please write who has it in the line. Do not include the patient that is being seen in the Allergy Clinic.

□ Asthma\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Hives\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Nasal allergies\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Swelling (angioedema) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Sinus infections\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Immunodeficiency\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Eczema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other illnesses (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Food allergy\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ No family illness\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Social History:** (please circle the appropriate *italicized* answer when possible)

With whom do you live? *spouse* *mother father siblings (how many\_\_\_\_\_) others:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

For pediatric patients:

Does your child have brothers and/or sisters: *Yes No*

If yes, please indicate if brother or sister and ages of each sibling:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Does your child attend daycare? *Yes No*

Does your child attend school? *Yes No*

If yes, what grade? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mother’s occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Father’s occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do both parents live in the same home? *Yes No*

If no then who is primary care giver? *Mother Father Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Does child spend time with noncustodial parent? *Yes No*

If yes, how often is child with noncustodial parent?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Environmental History:**

Do you live in a: *house apartment condominium duplex mobile home other:* \_\_\_\_\_\_\_\_\_\_\_\_\_

How old is your home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your home heated by: *gas electric propane wood other:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your home cooled by: *central air conditioning window air conditioning fans none*

Does your house have a basement or crawlspace? *Yes No*

If you have a basement or crawlspace would you describe this area as: *dry damp wet unknown*

If you have a basement, does your child spend time in the basement? *Yes No*

What type of flooring is in your bedroom? *carpet wood tile other:* \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any pets in the house? *Yes No*

If yes, specify what type and how many? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there tobacco use in the family? *Yes No*

Additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Thank you for completing this form. Please provide additional comments to the medical provider.**

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