CAROLINA ASTHMA and ALLERGY CENTER, PA

PRE-VISIT QUESTIONNAIRE

In an attempt to serve you in a timely fashion, we are furnishing you with this questionnaire with the request that you complete this information *prior to your scheduled visit.* We look forward to seeing

Your Name: **Date of Birth:** **Date of Visit:** **Acct.#** **(to be filled-in by staff)**

Current Medications and/or Supplements (e.g., vitamins)
(Please list all medicines you are currently taking for any reason)

Name of Medicine	Dose	How often are you taking?	Name of Medicine	Dose	How often are you taking?

Please document any medicines to which you are allergic and the type of reaction (e.g., rash)

Other Medical Conditions:

Past Allergy History:

1. Have you seen an allergist in the past for your symptoms? Yes ❑ No ❑

a. If yes: Doctor's Name: When?

b. Did you have skin testing? Yes ❑ No ❑

c. Prior diagnosis: ❑ Allergic Rhinitis ❑ Asthma ❑ Hayfever ❑ Hives ❑ Eczema ❑ Urticaria ❑ Insect sting

d. Prior treatment: ❑ None ❑ Prescription meds ❑ Allergy shots ❑ Over-the-counter meds ❑ Avoidance measures

If you have been treated in the past it would be helpful if you could bring your previous records to your visit.

General Childhood History:

1. Were there any complications at birth? Yes ❑ No ❑

2. Childhood illnesses: ❑ Routine illnesses ❑ Recurrent ear infections ❑ Recurrent sore throat ❑ Recurrent sinus infections
❑ Skin Rashes ❑ Respiratory difficulty ❑ Mumps ❑ Measles ❑ Chickenpox ❑ Allergies ❑ Asthma

3. Immunizations: ❑ N/A ❑ Current ❑ Not Current

Family History:
Please indicate if your family member has had any of the following:

Disease	Father	Father's		Mother	Mother's		Sister	Brother	Daughter	Son
		Mother	Father		Mother	Father				
Asthma										
Cystic Fibrosis										
Hay fever										
Eczema										
Heart disease										
Thyroid disease										
Arthritis/Lupus										
Bronchitis										
Food Allergies										
Migraine Headaches										
Diabetes										
Cancer										

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PRE-VISIT QUESTIONNAIRE (continued)

Social History:

1. Marital Status: ❑ Married ❑ Single ❑ Divorced ❑ Separated ❑ Widowed ❑ N/A

2. Number of children:

3. Do you smoke? Yes ❑ No ❑ If yes: ❑ less than 1 pk/wk ❑ less than 1 pk/day ❑ 1-2 pks/day ❑ more than 2 pks/day

4. How long have you smoked? ❑ Less than 5 yrs. ❑ 5-10 years ❑ 10-20 years ❑ more than 20 years

5. Have you stopped? Yes ❑ No ❑ If yes: ❑ this year ❑ 1-3 years ago ❑ more than 3 years ago

6. Are you exposed to secondary smoke? Yes ❑ No ❑ If yes: ❑ Home ❑ Work

7. Do you chew tobacco or dip snuff? ❑ Yes ❑ No

8. Alcohol(wine/beer): ❑ No ❑ Daily ❑ Occasionally ❑ Weekly

9. Days absent from school/work due to illness? ❑ 0 ❑ less than 5 ❑ 5-10 ❑ 10-15

10. Occupation:

Are there any unusual exposures on the job? ❑ Yes ❑ No If yes, please describe (e.g. toxins, mold)

Environmental History:
Please check the appropriate boxes. (In some cases you may need to check more than one box)

1. **Home Location**: ❑ Inner City ❑ Urban(City) ❑ Suburbs ❑ Rural (Country) **Age of home:**

2. **Home Type:** ❑ Apartment ❑ Condo ❑ House ❑ Mobile Home

3. **Air Conditioning:** ❑ None ❑ Central ❑ Window ❑ Ceiling fans ❑ Window fans

4. **Heat:** ❑ Baseboard ❑ Forced Air ❑ Electric ❑ Gas ❑ Heat pump ❑ Oil ❑ Radiant ❑ Radiator ❑ Space Heater ❑ Wood Stove

5. **Filters:** ❑ None ❑ Electrostatic ❑ Fiberglass ❑ Hypoallergenic

6. **Mold:** ❑ None ❑ Baseboards ❑ Basement ❑ Bathroom ❑ Crawl Spaces ❑ Windows

7. **Bedroom Floor:** ❑ Area rug ❑ Cement ❑ Full carpet Pile: ❑ Low ❑ Med ❑ High ❑ with pad ❑ no pad ❑ Hardwood ❑ Linoleum ❑ Tile

8. **Bedroom Windows:** ❑ Bare Curtains: ❑ washable ❑ non washable ❑ Miniblinds ❑ Roll-up blinds ❑ Shades ❑ Plantation/Wooden blinds

9. **Mattress:** ❑ Old ❑ New ❑ Crib ❑ Foam ❑ Inner spring ❑ Waterbed ❑ Encased ❑ Not Encased

10. **Pillows:** ❑ Dacron ❑ Feather ❑ Foam ❑ None ❑ Encased ❑ Not Encased

11. **Objects in bedroom:** ❑ Cluttered ❑ Somewhat cluttered ❑ Uncluttered

12. **Pets:** ❑ Cats ❑ Dogs ❑ Indoor/❑ Outdoor

Other animals: ❑ Bird ❑ Hamster ❑ Horse ❑ Gerbil ❑ Rabbit ❑ Farm Animals ❑ Indoor/❑ Outdoor

13. **Hobbies/Sports:** ❑ None ❑ Indoor ❑ Outdoor