Whitewater Immunology
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Adult History Questionnaire (age >17 yrs)

PLEASE PRINT AND BRING THIS FORM COMPLETELY FILLED OUT TO YOUR APPOINTMENT.

BRING ALL YOUR MEDICATIONS AND VITAMINS WITH YOU TO THE CLINIC.

Name:______________________________ E-mail:___________________________

Cell phone:_____________________(ok to send texts? Y N) Work phone (optional): _______________

Preferred pharmacy:____________________________________ phone: ( ) _____________

Secondary pharmacy: :__________________________________ phone: ( ) _____________

Primary Care Physician:		*Referring Physician (if different):*	
Name:	____________________	Name:	____________________
Telephone:	____________________	Telephone:	____________________
Other provider(s) to whom you would like note sent:		____________________________________	

Reason for your visit to the allergy and immunology clinic:

____

____

____

1. Approximate date symptoms began ____
2. Things that make symptoms worse____
3. Symptoms worse in (*circle all*): Winter Spring Summer Fall year round change of seasons
4. Medications that **have** helped ____
5. Medications that **have not** helped _______________________________________
6. Have you ever taken oral corticosteroids (e.g. Prednisone or Medrol) or steroid injections? Y N
   Date of last treatment with corticosteroids _______________# of treatments in last year:____
7. Have you ever been to the emergency room for your symptoms? ______________Date:__________
8. Do you have a reaction to bees? Y N Local reaction or systemic?__________________
9. Do you carry an Epi injector? Y N Expiration date:________________
10. Do you wake at night with shortness of breath? Y N How many times a week? ___________
11. Do you snore? Y N Have you been told that you stop breathing when you sleep? Y N
12. How is your sense of smell? Excellent ________ Good ________ Poor _________ Absent ______
13. Do you have any problems with your voice? _____________________________________
14. If you have had recurrent infections, what types of infections?_______________________
    Number of courses of antibiotics in the last year? ____________________________________

If you have asthma, do any of the following precipitate asthma attacks? (circle all that apply)

Acid reflux tobacco smoke strong odors foods (list:____)

Pain medications respiratory/sinus infections exercise cold air animals emotions stress

Other triggers:____

Medical/Surgical History *(circle all that apply)***:**

Asthma COPD Eosinophilic esophagitis GERD HTN Hives/urticaria DM GERD Thyroid disease

Eczema/atopic dermatitis allergic contact dermatitis Environmental allergies (pollen mold cat dog mites)

Previous skin tests Yes θ No θ Previous Allergy Shots Yes θ No θ Were they effective?________

Previous X-rays or CT scans (and location done): ____

Food allergies (list foods): ____

Cancer (type): ____________________If you have autoimmune disease, which one(s): __________________

____

Other pertinent medical history: ____

Surgeries (include year): appendectomy ( ) Tonsils/adenoids ( ) Ear tubes ( ) Sinus surgery ( )

cholecystectomy ( ) hysterectomy ( ) Shoulder R L ( ) Knee R L ( ) wisdom teeth ( )

Other surgeries: ____

Please list all medication allergies, **your reaction** and the approximate year of the reaction:

____

____

____

Immunizations – *MOST Important for evaluation of immune system*	**Date**	**Immunizations**	**Date(s)**
Tetanus/TDaP (most recent)		Pneumovax 23, Prevnar (13, 15, 20, 21)	
Influenza – (most recent)		H influenza B (if received as an adult)	

Family Medical History (*circle/fill in as appropriate*):

Father (age) Asthma Allergies HTN High Chol Diabetes Other: ________________________________

Mother (age) Asthma Allergies HTN High Chol Diabetes Other: ________________________________

Brother/sister (age) Asthma Allergies Other: ____

Brother/sister (age) Asthma Allergies Other: ____

Brother/sister (age) Asthma Allergies Other: ____

Brother/sister (age) Asthma Allergies Other: ____

Brother/sister (age) Asthma Allergies Other: ____

Paternal Grandfather Asthma Allergies HTN High Chol Diabetes Other: ___________________________

Paternal Grandmother Asthma Allergies HTN High Chol Diabetes Other: ___________________________

Maternal Grandfather Asthma Allergies HTN High Chol Diabetes Other: ___________________________

Maternal Grandmother Asthma Allergies HTN High Chol Diabetes Other: ___________________________

Any family members with autoimmune disease or recurrent infections (or diagnosed with immune deficiency)?

____

____

Social History:
Marital Status: S_____ M_____ Partner: _____ D_____ W_____ Number of children:_______

Smoking History:
☐ None ☐ Yes average packs a day: _____ (years smoked: _____) If you quit, which year?________

☐ Vaping (cartridges per week:____) Year started: _____ (or if in past, number of years you vaped: _____)

☐ Currently chew tobacco (years chewed:______) ☐ Current marijuana user (smoke edible sublingual)

Alcohol History:
☐ None ☐Yes, _____________(# of beers or glasses of wine or drinks /day) *if less than daily - specify*

Living Environment:

☐ House or ☐ apartment? Type of heat? ☐ forced air, ☐ electric, ☐ radiator, ☐ wood stove ☐ other _____

Humidifier?	Yes ☐	No ☐	Water damage/mold in home?	Yes ☐	No ☐
Hot tub?	Yes ☐	No ☐	Feather pillow or bedding	Yes ☐	No ☐

Pets:			Access to Bedroom?		Sleep in the Bed?	
Dogs (#)	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐
Cats (#)	Yes ☐	No ☐	Yes ☐	No ☐	Yes ☐	No ☐

Pet Birds (type, number of birds and location in home): ____

Other pets/animals (including horses/cows/chickens): ____

Hobbies: ____

Employment: Occupation(s), current and past:____

Exercise: Yes ☐ No ☐ Type____

Duration (hours per session):_____________ Number of days/week:__________________________

Review of Systems (circle any that apply):

General: weight gain weight loss fevers chills fatigue trouble sleeping

Head and eyes: headaches migraines itchy eyes painful eyes

Nose, mouth and throat: sinus pain/pressure runny nose post nasal drip nasal congestion

sore throat recurrent sinus infections pain with swallowing

Seasonal problems: Winter Spring Summer Fall Animal triggers:________________________

Lungs: dry cough productive cough (color of sputum____________) trouble breathing in

trouble breathing out wheeze shortness of breath shortness of breath with exercise

pneumonia (# times_____) premature birth past intubation for respiratory failure/sepsis

Seasonal problems: Winter Spring Summer Fall Animal triggers:_________________________

Heart: palpitations past heart attack swollen legs history of heart murmur

Digestion/GI: indigestion (triggers____________) diarrhea constipation bloating

getting foods stuck in the esophagus/choking on certain foods (list foods___________________________)

Genitourinary: waking at night to urinate/slow stream

Psychiatric: anxiousness (high med low) stress (high med low) depression

Skin: rashes hives dry skin itchy skin eczema/atopic dermatitis skin infections

Muscles and joints: joint pains (list joints: ____________________________________) muscle aches

Thyroid and endocrine: hot/cold intolerance diabetes (insulin dependent?) Graves/Hashimoto's disease

Blood/Lymph: anemia past lymphoma or cancer blood infections/sepsis

General state of health: Excellent Good Fair Poor

Other pertinent symptoms:____

____

____

Medications:

Asthma/COPD Inhalers (circle strength you are using, fill in frequency of use):

Advair Diskus (100/50 250/50 500/50) HFA (45/21 115/21 230/21) AirDuo (55/14 113/14 232/14)
Breo Ellipta (100/5 200/5) Symbicort (80/4.5 160/4.5) Dulera (50/5 100/5 200/5)
QVAR (40 80) Pulmicort (90 180) Asmanex HFA (100 200) Asmanex Twist (110 220) Alvesco (80 160)
Flovent/fluticasone (44 110 220) Armon (55 113 232) Arnuity Ellipta (100 200)
Anoro Ellipta 62.5/24 Bevespi 62.5/4.8 Stiolto 2.5/2.5 Utibron 27.5/15.6 Trelegy 11/62.5/25
Seebri Incruse Ellipta Spiriva Handihaler Spiriva Respimat (1.25 2.5) Tudorza Atrovent Combivent
Arcapta Neohaler Serevent Diskus Striverdi Respimat # puffs: _____ # times daily:_____ as needed
Other inhalers (including Primatene Mist):____

Proair (HFA/RespiClick) Proventil Ventolin Albuterol (HFA/nebs) Xopenex/levalbuterol (HFA/nebs)
once daily twice daily before exercise as needed (*circle all that apply*)

Nasal treatments (circle kind and how used):

Flonase/fluticasone Nasacort/triamcinolone Nasonex/mometasone flunisolide daily 2 x daily as needed
Astepro or Astelin (generic for azelastine) Patanase/olopatadine Atrovent/ipratropium (0.03% 0.06%)
Afrin 4-Way oxymetazoline Wilson's (gentamycin) solution Mupirocin irrigations
Nasal irrigations Bottle/Neti pot (with fluticasone or budesonide?) once daily twice daily as needed

Oral Allergy medications (circle medication/dosing):

Singulair/montelukast 10 mg daily seasonally as needed or tried, but didn't seem to work
Allegra/fexofenadine 60/180 mg Zyrtec/cetirizine 10 mg Xyzal 5 mg Claritin/loratadine 10 mg daily as needed
Benadryl/diphenhydramine 25 mg scheduled or as needed (*don't drive for 6 hours after taking Benadryl*)
Sudafed/pseudoefedrine Hydroxyzine/Atarax/Vistaril: ______ mg scheduled before bed as needed

Skin treatments (topical prescription steroids & over-the-counter – even ones you rarely use):

Hydrocortisone (2.5% 1%) Triamcinolone 0.1% Mometasone 0.1% Protopic/tacrolimus (0.1% 0.03%)
Elidel/pimecrolimus Eucrisa/crisaborole Other:____

Over the counter (PLEASE CIRCLE IF EVEN RARELY TAKEN):

Advil/ibuprofen Aleve/naproxen Aspirin (81 325 mg) Tylenol/acetaminophen
Prilosec/omeprazole Prevacid/lansoprazole esomeprazole pantoprazole famotidine (10 20 mg)
Vitamin D (daily) 400 IU 800 IU 1000 IU 2000 IU 4000 IU 5000 IU > 5000 IU daily (amount:__________)

Prescription medications for other conditions *(including eye drops – use back if needed)***:**

Medication:________________________________mg # times daily ____ or as needed
___________________________________mg # times daily ____ or as needed
___________________________________mg # times daily ____ or as needed
Biologics or other injections at home or at infusion center:____