Allergy & Asthma Affiliates
2121 Highland Avenue / Knoxville, TN 37916
Phone: (865) 525-2640

New Patient Questionnaire

Print clearly, and check '✓' all that apply. Answer all questions from the patient's point of view. Mark "N/A"—if not applicable.

PATIENT'S NAME (First Name, Middle Name, Last Name)	HOME TELEPHONE ( )	GENDER ☐ M ☐ F	DATE OF BIRTH / /	RACE
PATIENT'S ADDRESS (Street, City, State, Zip)		WORK TELEPHONE ( )		
PRIMARY CARE PHYSICIAN (First Name, Last Name)	TELEPHONE ( )	REFERRING PHYSICIAN (First Name, Last Name)	TELEPHONE ( )	
PRIMARY CARE PHYSICIAN'S ADDRESS (Street. City, State, Zip)		REFERRING PHYSICIAN'S ADDRESS (Street. City, State, Zip)		
WHO COMPLETED THIS QUESTIONNAIRE? (if other than patient)	RELATIONSHIP TO PATIENT	Affix Patient Label Here		
HAVE ANY OTHER FAMILY MEMBERS BEEN SEEN BY US? ☐ No ☐ Yes, if so, who?				

CHIEF COMPLAINT

1. Describe the reason for your visit and what problems or symptoms you are having.

HISTORY OF PRESENT ILLNESS

2. Timing. When did the symptoms begin?

3. Quality. If pain, what does it feel like? ☐No pain

4. Severity. How severe are the symptoms? (Circle one)

1 2 3 4 5
mild very severe

5. Duration. How often do you have symptoms?

6. Context. Do symptoms occur at certain times or places?

7. Location. Where are the symptoms located?

8. Modifying Factors. Does anything make the symptoms worse?

9. Modifying Factors (Cont.). Does anything make the symptoms better?

10. Assoc. Symptoms. Does anything else occur at the same time of your major problem(s)?

***** FOR OFFICE USE ONLY *****

Referral Source: ☐ PCP ☐ FOF ☐ YP ☐ OTH

I was asked to see this patient in consultation

by:

for:

Level 3 = 1 to 3 elements
Level 5 = 4+ elements or 3 chronic / inactive

HPI Level		Provider Initial

REVIEW OF SYSTEMS

11. Are you bothered by any of the following symptoms in the following body systems? Mark ('✓') 'Yes' or 'No' for each.

GENERAL	YES	NO
Always tired	( )	( )
Chills / Fever	( )	( )
Loss of appetite	( )	( )
Night sweats	( )	( )
Recurrent infections	( )	( )
Trouble sleeping	( )	( )
Weight gain / loss	( )	( )

EYES	YES	NO
Darkness under eyes	( )	( )
Drainage	( )	( )
Vision change	( )	( )
Eye pain	( )	( )
Itchy eyes	( )	( )
Light sensitivity	( )	( )
Red eyes	( )	( )
Watery eyes	( )	( )

HENT	YES	NO
(Head)		
Headaches	( )	( )
Sinus pain	( )	( )
	( )	( )
Sinus infections	( )	( )
(Ears)		
Ear ache/pain	( )	( )
Decreased hearing	( )	( )
Ear drainage	( )	( )
Ear infections	( )	( )
Ringing or popping ears	( )	( )
(Nose)		
Sneezing	( )	( )
Runny nose	( )	( )
Loss of smell	( )	( )
Stuffy nose	( )	( )
Itchy Nose	( )	( )
Nosebleeds	( )	( )
Excessive snoring	( )	( )
(Throat / Mouth)		
Sore throat	( )	( )
Hoarseness / laryngitis	( )	( )
Difficulty swallowing	( )	( )
Loss of taste	( )	( )
Itchy roof of mouth	( )	( )

CARDIOVASCULAR	YES	NO
Shortness of breath w/exertion	( )	( )
Bluish fingers or lips	( )	( )
Near fainting	( )	( )
High blood pressure	( )	( )
Swelling of feet, ankles or hands	( )	( )
Cold hands or feet	( )	( )
Heart trouble	( )	( )

RESPIRATORY	YES	NO
Chest tightness	( )	( )
Cough (wet)	( )	( )
Cough (dry)	( )	( )
Coughing up blood	( )	( )
Frequent colds or bronchitis	( )	( )
History of pneumonia	( )	( )
Shortness of breath	( )	( )
Wheezing	( )	( )

GASTROINTESTINAL	YES	NO
Abdominal bloating	( )	( )
Abdominal pain	( )	( )
Bloody stools	( )	( )
Nausea or vomiting	( )	( )
Vomiting blood	( )	( )
Belching or excess gas	( )	( )
Constipation	( )	( )
Indigestion / heartburn	( )	( )
Diarrhea	( )	( )

GENITOURINARY	YES	NO
Urinary frequency	( )	( )
Painful urination	( )	( )

MUSCULOSKELETAL		
Joint swelling	( )	( )
Stiffness	( )	( )
Joint pain	( )	( )
Muscle aches / cramps	( )	( )
Redness	( )	( )

SKIN	YES	NO
Rash	( )	( )
Birthmarks	( )	( )
Hives / welts	( )	( )
Itching	( )	( )
Dry skin	( )	( )
Change in skin color	( )	( )
Swelling	( )	( )
Bruising	( )	( )
Abrasions	( )	( )
Skin infections	( )	( )

ALLERGIC	YES	NO
Seasonal allergies	( )	( )
Hay fever	( )	( )
Reaction to foods or drugs	( )	( )

NEUROLOGIC	YES	NO
Headaches	( )	( )
Dizziness or poor balance	( )	( )

HEMATOLOGIC/LYMP.	YES	NO
Swollen glands	( )	( )
Anemia / low blood	( )	( )

ENDOCRINE	YES	NO
Hair loss	( )	( )

List any other symptoms or concerns you have:

____

____

***** FOR OFFICE USE ONLY *****

Affix Patient Label Here

☐ All Systems Negative Except Noted

Level 3 = 1 Area
Level 4 = 2 - 9 Areas
Level 5 = 10+ Areas

ROS Level		**Provider Initial**

PAST MEDICAL HISTORY

12. MEDICATIONS. List any prescriptions, including bronchodilators, antibiotics, etc. and over-the-counter medicines, including vitamins, supplements and herbals you are currently taking or have taken within 60 days.

a.

Medication	Strength	How Often

13. OTHER ILLNESSES. List any illnesses or conditions you have ever had.

a.

Condition / Illness	Age	Currently Being Treated?	Current Physician	Current Status
		☐ Yes ☐ No		☐ Resolved ☐ Active ☐Stable ☐ Worse
		☐ Yes ☐ No		☐ Resolved ☐ Active ☐Stable ☐ Worse
		☐ Yes ☐ No		☐ Resolved ☐ Active ☐Stable ☐ Worse
		☐ Yes ☐ No		☐ Resolved ☐ Active ☐Stable ☐ Worse
		☐ Yes ☐ No		☐ Resolved ☐ Active ☐Stable ☐ Worse

14. FEMALES ONLY (☐ Not applicable)

a. Last Known menstrual period ____/____/____

b. Chance of pregnancy? ☐ Yes ☐ No

15. IMMUNIZATIONS.

a. Are your immunizations current? ☐ No ☐ Yes

b. Do you receive annual flu vaccines? ☐ No ☐ Yes

16. REACTIONS. Please list any food, drug, or insect reactions or side effects you currently have or have had at some point in your life. ☐ None

a.

Cause	Type of Reaction or Side Effect
	☐Rash/hives ☐Swelling ☐Itching ☐Short of Breath
	☐Rash/hives ☐Swelling ☐Itching ☐Short of Breath
	☐Rash/hives ☐Swelling ☐Itching ☐Short of Breath
	☐Rash/hives ☐Swelling ☐Itching ☐Short of Breath

b. Have you ever had allergy skin testing? ☐ No ☐ Yes

c. Have you ever been on allergy injections? ☐ No ☐ Yes

17. SURGERIES / INJURIES. List any surgeries or injuries since birth.

a.

Surgery or Injury	Performed by	Complications?	Outcome	Where	Age or Yr

b. Any previous injury to nose? ☐ No ☐ Yes

18. HOSPITAL / ER VISITS. List any hospital or ER visits within the last 5 yr

a.

Reason	Length of Stay	Complications	Hospital	Age or Yr

19. PAST TRANSFUSIONS

a. Have you ever had blood or blood product transfusions? ☐ No ☐ Yes

*** FOR OFFICE USE ONLY ***

Affix Patient Label Here

Provider Initial

PEDIATRIC PAST MEDICAL HISTORY

*** FOR OFFICE USE ONLY ***

Affix Patient Label Here

***** Complete #20 - # 23 only if patient is a minor *****

20. PREGNANCY & BIRTH

a. Is your child yours by: ☐ Birth ☐ Adoption ☐ Stepchild ☐ Foster
b. Birth weight: _______ Type of Delivery: ☐Vaginal ☐ Caesarian
c. Age of mother at time of delivery ________
d. ☐ Full term or ☐ Premature How many wks premature? _____
e. Any delayed separation of umbilical cord (> 1 month) ? ☐ No ☐Yes
f. Prolonged jaundice over 2 weeks? ☐ No ☐ Yes
g. Intestinal obstructions during infancy? ☐ No ☐ Yes
h. Any other newborn problems? ☐ No ☐ Yes
____

21. NUTRITION & FEEDING

a. Was your child breastfed? ☐ No ☐ Yes If so, how long? _____
b. Was you child bottle-fed? ☐ No ☐ Yes If so, how long? _____
c. Were formula changes required? ☐ No ☐ Yes
d. Has your child had any feeding/dietary problems? ☐No ☐Yes

22. DEVELOPMENT

a. Has you child had any of the following delays? Circle if so.
Walking Learning Talking
b. Any difficulties with growth or weight gain? ☐ No ☐ Yes

23. SCHOOL HISTORY

a. Did/does your child attend preschool? ☐ No ☐ Yes
b. How many days of missed school in the last year due to illness? ____
c. Is your child in daycare? ☐ No ☐ Yes
How many days per week?_______
At what age did they start daycare? ______
d. What grade is your child in? (Circle one) ☐ N/A
P K 1 2 3 4 5 6-8 9-12
e. School performance: ☐Above average ☐Average ☐Below average

FAMILY HISTORY

24. Place a check mark under the appropriate family member if they have experienced any of the following conditions or diseases. Write in any conditions or diseases not listed.

Condition	Mom	Mom's Mom	Mom's Dad.	Dad	Dad's Mom	Dad's Dad	Sis.	Bro.	Other
Allergies / hay fever	☐	☐	☐	☐	☐	☐	☐	☐	☐
Asthma / RAD	☐	☐	☐	☐	☐	☐	☐	☐	☐
Bronchitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lung disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sinusitis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cystic Fibrosis	☐	☐	☐	☐	☐	☐	☐	☐	☐
Immune deficiency	☐	☐	☐	☐	☐	☐	☐	☐	☐
Migraine headaches	☐	☐	☐	☐	☐	☐	☐	☐	☐
Recurrent Infections	☐	☐	☐	☐	☐	☐	☐	☐	☐
Stomach Conditions	☐	☐	☐	☐	☐	☐	☐	☐	☐
Food allergies	☐	☐	☐	☐	☐	☐	☐	☐	☐
Skin disease	☐	☐	☐	☐	☐	☐	☐	☐	☐
Lupus	☐	☐	☐	☐	☐	☐	☐	☐	☐
Rheumatoid Arthritis	☐	☐	☐	☐	☐	☐	☐	☐	☐
_______________	☐	☐	☐	☐	☐	☐	☐	☐	☐
_______________	☐	☐	☐	☐	☐	☐	☐	☐	☐

Provider Initial

SOCIAL HISTORY

Affix Patient Label Here

25. TOBACCO USE / EXPOSURE

a. ☐ None ☐ Current Use ☐ Prior Use
(Year Started ______ Year Quit _______)
Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Smokeless
How many times/packs per day? ____

b. How often are you exposed to second-hand smoke? ☐ Sometimes in public/work ☐ Often in public / work ☐ Sometimes at home ☐ Often at home

c. How many smokers in home? ☐ None ☐ 1 ☐ 2 ☐ 3 ☐ more than 3

26. FAMILY SITUATION

a. Marital Status: ☐Single ☐Married ☐Separated ☐Divorced ☐Widowed

b. If a minor, are child's parents: ☐ Married ☐Unmarried ☐Separated ☐Divorced

c. Who lives at home with you?

Name	Age	Relationship	Occupation	Highest Education Level
____________	_____	____________	____________	☐ Elem. ☐ Jr. High ☐ High School ☐ College
____________	_____	____________	____________	☐ Elem. ☐ Jr. High ☐ High School ☐ College
____________	_____	____________	____________	☐ Elem. ☐ Jr. High ☐ High School ☐ College
____________	_____	____________	____________	☐ Elem. ☐ Jr. High ☐ High School ☐ College
____________	_____	____________	____________	☐ Elem. ☐ Jr. High ☐ High School ☐ College
____________	_____	____________	____________	☐ Elem. ☐ Jr. High ☐ High School ☐ College

d. In the past year, have there been family changes? (Check all that apply)
☐ Marriage ☐ Separation ☐ Divorce ☐ Loss of Job ☐ Move ☐ New School ☐ Birth ☐ Serious illness ☐ Death ☐ Other

27. ACTIVITY/EXERCISE LEVEL (Answer only one)

a. ☐ Inactive—no regular physical activity (Ex. sit-down job)
☐ Light activity—no organized physical activity during leisure time.
☐ Moderate activity—occasionally involved in activities (Ex. jogging)
☐ Heavy activity— Exercise or active sports at least three times per week

b. Type of activity(ies): _________________ ___________________

c. Any limitation of athletic or work activities? ☐ No ☐ Yes

28. DIET

a. The majority of my meals are ☐Fast-food ☐Home-cooked ☐Restaurant

b. Do you follow a special diet? ☐ No ☐ Yes If so, please describe:
____

c. Caffeine drinks: ☐Coffee ☐Tea ☐Soft Drinks How many per day?____

29. DEMOGRAPHICS

a. ☐ Child / Student ☐ Employed ☐ Retired ☐ Unemployed ☐ Disabled
Employer / School: _______________________________
Birthplace: ______________________________________

b. Number of missed school or workdays because of illness? ______

c. Any occupational exposures to chemicals, fumes, etc? ☐ No ☐ Yes

d. Education: ☐ K – 12 ☐ Some College ☐ Degree Obtained

***** FOR OFFICE USE ONLY *****

Provider Initial

ENVIRONMENTAL HISTORY

Affix Patient Label Here

PATIENT'S RESIDENCE

30. What is the age of your home? ☐0 – 10 years ☐11–15 years ☐16 – 20 years ☐> 20 years

31. How long have you lived at current residence? ☐1 year or less ☐1 – 5 years ☐6 - 10 years ☐over 10 years

32. What type of home do you live in? ☐Frame house ☐Brick house ☐Apartment ☐Mobile Home ☐Other ________

33. Where is your home located? ☐City ☐Suburb ☐Country / Rural ☐Farm ☐Near water ☐Other

34. Does your home have a basement? ☐No ☐Yes If "Yes" ⇨ ☐Water leaks ☐Damp ☐Previous problems with leaks

35. What type of heating? ☐Central or ☐Space: ☐gas ☐electric ☐oil ☐wood ☐kerosene

36. What type of air conditioning? ☐Central ☐Window ☐None

37. How often are air filters changed? ☐N/A ☐Weekly ☐Monthly ☐Less often

38. What other "air" devices do you use? ☐Fans ☐Dehumidifiers ☐Humidifiers ☐Air filter/cleaner

39. Is there any noticeable mold or mildew? ☐No ☐Yes If "Yes", where? ☐Bathrooms ☐Basement ☐Bedrooms ☐Kitchen

40. Is there any fume exposure? ☐No ☐Yes If "Yes", what type? ☐Cleaning supplies ☐Aerosols ☐Fragrances ☐Paint / Varnish

41. Do you spend time at other residences? ☐No ☐Yes

42. Is there any animal exposure? ☐No ☐Yes If "Yes", indicate the number of each animal. If other, write in what type and how any.

Animal Exposure

Location	Dog	Cat	Bird	Rodent	Horse	Farm Animals	Other
At home, indoors							
At home, outdoors							
Other							
School / Sitter							

43. Do you have any indoor plants or flowers? ☐ No ☐ Yes If so, how many? ☐ 1 – 5 ☐ 6 – 10 ☐ 11 – 20 ☐ over 20

44. Have there been any pest problems? ☐ No ☐ Yes If so, what? ☐ Roaches ☐ Other insects ☐ Mice ☐ Other: _________

45. Where does the problem seem to be worse? ☐Bedroom ☐Living room ☐Kitchen ☐Basement ☐Garage ☐Indoors ☐Outdoors

PATIENT'S BEDROOM

46. Indicate the items found in patient's bedroom. ☐ Mattress pad ☐ Stuffed furniture ☐ Heavy drapes ☐ Venetian blinds ☐ Carpeting ☐ Bookcase ☐ Quilts/Comforters ☐ Stuffed toys ☐ Plants

47. How many beds in bedroom? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

48. How many persons in bedroom? ☐ 1 ☐ 2 ☐ 3 ☐ 4 or more

49. What type of mattress? ☐ Spring ☐ Foam ☐ Bunk ☐ Water ☐ Crib ☐ Other_________

50. What type of pillow? ☐ Cotton ☐ Feather ☐ Foam ☐ Polyester ☐ Other _________

51. Are vinyl covers used? ☐ No ☐ On mattress ☐ On pillows

52. What type of flooring? ☐ Carpet ☐ Hardwood ☐ Tile ☐ Linoleum

Thank you for taking the time to complete this questionnaire! Please bring this with you for your appointment.

***** FOR OFFICE USE ONLY *****

Level 4 – 1 element
Level 5 – 2+ elements

PMFSH Level		Provider Initial