**Park Allergy Center**

Michael Park, MD
Lucetta Lyford, PA-C

430 W Centre Ave
Portage, MI 49024

Phone: (269)321-6673
Fax: (269)324-5594

# ALLERGY/ASTHMA QUESTIONNAIRE

How did you hear about us: (circle) Physician Referral Family/Friend Website Phonebook Other_____

Name:_____ Age:_____ Appointment Date:_____

Birthdate:_____Occupation/Place of Work:_____

**Please Circle**: African American Asian Caucasian Hispanic Middle Eastern Other: _____

**Describe the problem(s) you have been experiencing:**_____

_____

_____

**Length of time you have had the problem(s):**_____

**If you have been away from home in the past year, were symptoms better or worse while there? (Circle) Better Worse No Difference**

**Which season(s) bother your symptoms the most? (Circle)**
**All the time Spring Summer Fall Winter Changes of seasons**

**Previously evaluated by an allergist? (circle)** Yes No **If yes, who and when:**_____

_____

**Were skin test performed? (circle)** Yes No **If yes, what were the results:**_____

_____

**Have you ever received allergy shots before? (circle)** Yes No **If yes, when did you start and end your treatment?**_____

**If yes, did you feel allergy shots were helpful? (circle)** Yes No

## ALLERGY HISTORY

**Do you live in a (circle):** House Apartment Condo Dorm Mobile Home Other_____

**Age of dwelling/Year built:**_____**Length of Occupancy:**_____

**Mattress (circle)**: Conventional Water Air Other_____**How old?** _____

**Pillow (circle)**: Feather Foam Dacron/Polyester Other_____**How old?**_____

PATIENT NAME:_____

**Animal Exposure at home or work**: Cat _____ Dog _____ Horse _____ Other _____

**Ever been stung by a bee, wasp, hornet? (circle)** Yes No **If yes, describe the reaction**_____

**Ever had poison ivy/oak/sumac? (circle)** Yes No **Stuffy nose that worsens at night (circle)?** Yes No

Adverse reaction to medications (specify name/reaction):_____

Adverse reaction to foods (specify food/reaction):_____

Adverse reaction to latex or rubber:_____

Adverse reaction to previous immunizations:_____

Current medications:_____

_____

Past and current medical problems:_____

_____

Past surgeries:_____

## SOCIAL HISTORY

**Who lives with you in your home (circle)**: Live alone Roommate Significant other Spouse Children Parents Siblings

**Does anyone in your home smoke:** Yes No
**Patient's smoking status (circle)**: Current Former Never

**Alcohol use (circle)**: Daily Weekly Monthly Yearly Never

**Children (circle)**: Yes No **If yes, how many boys?**_____ **girls?**_____

## FAMILY HISTORY

**Parents (circle)**: Seasonal/Animal Food allergies Asthma Eczema Other_____

**Siblings (circle)**: Seasonal/Animal Food allergies Asthma Eczema Other_____

**Children (circle)**: Seasonal/Animal Food allergies Asthma Eczema Other_____

## REVIEW OF SYSTEMS

Circle and describe any other problems not mentioned above

| | | |
|---|---|---|
| Eyes | Muscles/bones/joints | |
| Ear/Nose/Throat | Skin | _____ |
| Heart | Neurological | |
| Lungs | Psychiatric | _____ |
| Gastrointestinal | Hormonal | |
| Genital/bladder/kidney | Blood/lymphatic | _____ |