Location:
OMA PAP NF

Midwest Allergy and Asthma Clinic, P.C.
16945 Frances St., Omaha, Nebraska 68130-2312 Phone: 402-397-7400

New Patient Questionnaire

Patient Name: _____ **Date of Visit:** _____
Birth Date: _____ **Age:** _____
Pharmacy: _____ **Referring Physician:** _____
Primary Care Physician: _____ **Child accompanied by (circle): father, mother, other**
Reason for Visit: (describe briefly) **May we provide your PCP a visit summary**? Yes No

_____
_____
_____
_____

In the past 12 months, have you been hospitalized more than once due to asthma? (Y / N)

In the past 12 months have you experienced the following symptoms or problems?

General/Constitutional:
- Chills Yes No
- Fatigue Yes No
- Fever Yes No
- Sleep disturbance Yes No
- Weight gain Yes No
- Weight Loss Yes No

Eyes:
- Redness Yes No
- Itching Yes No
- Watery Yes No
- Discharge Yes No
- Pain Yes No

ENT:
- Congestion Yes No
- Nasal itch Yes No
- Runny nose Yes No
- Sneezing Yes No
- Decreased hearing Yes No
- Decreased smell Yes No
- Ear pain Yes No
- Sinus pain Yes No
- Seasonal flare-ups Yes No
  - Worse in (circle): spring, summer, fall, winter

Cardiovascular:
- Shortness of breath at night Yes No
- Chest pain Yes No
- Fainting (syncope) Yes No
- Palpitations Yes No
- Leg or arm swelling (edema) Yes No

Respiratory:
- Snoring Yes No
- Asthma Yes No
  - If yes, age of diagnosis _____
- Cough Yes No
  - What aggravates it? _____
- Coughing up blood (hemoptysis) Yes No
- Shortness of breath Yes No
- Sputum production Yes No
- Wheezing Yes No

Gastrointestinal:
- Abdominal pain Yes No
- Diarrhea Yes No
- Difficulty swallowing Yes No
- Heartburn Yes No
- Nausea Yes No
- Vomiting Yes No

Musculoskeletal:
- Arthritis Yes No
- Muscle aches Yes No
- Swollen joints Yes No
- Weakness Yes No

Skin:
- Swelling episodes Yes No
- Dry skin Yes No
- Eczema Yes No
- Hives Yes No
  - Frequency _____
  - Location _____
  - Associated Bruising Yes No
  - Triggers _____
- Itching Yes No
- Rash Yes No

Neurologic:
- Numbness Yes No
- Dizziness Yes No
- Headaches Yes No

Psychiatric:
- ADHD Yes No
- Anxiety Yes No
- Depressed mood Yes No
- Psychiatric condition: _____

Endocrine:
- Diabetes Yes No
- Thyroid problems Yes No

Hematologic:
- Bruising Yes No
- Bleeding Yes No
- History of cancer Yes No

Allergy/Immunology:
- Frequent infections Yes No
- Food allergies Yes No
  - If yes, please list: _____
    _____

Patient Name: _____ **DOB:** _____

Current Medications:

Name of medication	Dose	Times/day	Condition being treated

Medical History:

Are your immunizations up to date? Yes No Are flu immunizations up to date? Yes No

Have you undergone allergy testing in the past? Yes No Have you been on allergy shots in the past? Yes No

List any chronic medical conditions that you are aware of, or being treated for: _____

_____

_____

Allergies / Intolerances: (I am allergic to the following…)

Medications	Foods	Stinging insects

Surgical History:

Year	Type of surgery

Hospitalizations:

Year	Reason

Family History: (Under each condition please write: father, mother, sibling, child, grandparent or extended family)

Allergic rhinitis	Asthma	Eczema	Angioedema	Food allergy	Immune disorder	Cancer

Social History:

Do you smoke? (Y / N) Have you ever smoked? (Y / N) Marital status: _____

Does anyone in your home smoke? Yes No Occupation: _____

What type of pets do you own? _____

Any additional information that you think the doctor should know about your situation?

_____

_____

_____

_____

_____