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: __ Dad __ Mom __ Other**
Chief Complaint: (describe briefly) **May we provide your PCP a visit summary**? __ Y __ N
_____
_____
_____
_____

In the past 12 months have you experienced the following symptoms or problems? Check ALL that apply:

General/Constitutional:
__ Chills
__ Fatigue
__ Sleep disturbance
__ Weight gain
__ Weight loss

Eyes:
__ Redness
__ Itching
__ Watery
__ Discharge
__ Pain

ENT:
__ Congestion
__ Nasal itch
__ Runny nose
__ Sneezing
__ Decreased hearing
__ Decreased smell
__ Ear pain
__ Sinus pain
__ Seasonal flare-ups
Worse in __ Spring __ Summer
__ Fall __ Winter

Cardiovascular:
__ Shortness of breath at night
__ Chest pain
__ Fainting (syncope)
__ Palpitations
__ Leg or arm swelling (edema)

Respiratory:
__ Snoring
__ Asthma
Age of diagnosis __
__ Cough
What aggravates it _____
__ Shortness of breath
__ Sputum production
__ Wheezing

Gastrointestinal:
__ Abdominal pain
__ Diarrhea
__ Difficulty swallowing
__ Heartburn
__ Nausea
__ Vomiting

Musculoskeletal:
__ Arthritis
__ Muscle aches
__ Swollen joints
__ Weakness

Skin:
__ Swelling episodes
__ Dry skin
__ Eczema
__ Hives
Frequency_____
Location_____
Triggers_____
Associated Bruising __Y __N
__ Itching
__ Rash

Neurologic:
__ Numbness
__ Dizziness
__ Headaches

Psychiatric:
__ ADHD
__ Anxiety
__ Depressed mood
__ Psychiatric condition:
Please list:_____

Endocrine:
__ Diabetes
__ Thyroid problems

Hematologic:
__ Bruising
__ Bleeding
__ History of cancer

Allergy/Immunology:
__ Frequent infections
__ Food allergies
Please list:_____

Current Medications:

Name of medication	Dose	Times/day	Condition being treated

Medical History:

Are your immunizations up to date? __ Y __ N Are flu immunizations up to date? __Y __ N

Have you undergone allergy testing in the past? __ Y __ N Have you been on allergy shots in the past? __Y __ N

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/vape? __ Y __ N

Have you ever smoked/vaped? __Y __ N

Does anyone in your home smoke? __Y __ N

What type of pets do you own? _____

Marital status: _____

Occupation: _____

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

_____

_____

_____

_____

_____