THE UNIVERSITY OF KANSAS PHYSICIANS

Department of Internal Medicine – Allergy & Immunology

Name: _____ Date: _____

Age: _____

Person completing the questionnaire if not the patient: _____

What are your symptoms: _____

When did your symptoms start: _____

Circle the symptomatic months: Jan Feb Mar Apr May Jun Jul Sep Oct Nov Dec All year round

Spring Summer Fall Winter

Review of systems (check all boxes that apply):

Gen: ☐fatigue ☐fever ☐chills ☐night sweats ☐sleep disturbance ☐migraines _____

Head: ☐headaches : quality - ☐dull ☐throbbing ☐pressure, frequency:_____

☐headache location - ☐forehead ☐cheeks ☐behind the eyes ☐temples ☐back of the head ☐band-like

Eyes: ☐itching ☐burning ☐redness ☐watering ☐swelling ☐shines (dark circles under eyes) ☐dryness

☐discharge ☐visual problems _____

Ears: ☐itching ☐pain ☐infections ☐tubes: years_____ ☐popping ☐hearing loss ☐fullness _____

Nose: ☐itching ☐sneezing ☐congestion (worse in the ☐AM ☐PM ☐all day) ☐drainage (color: _____)

☐post-nasal drip ☐snoring ☐runniness ☐blood ☐decreased smell ☐year of last sinus x-ray: _____

Throat: ☐soreness ☐redness ☐itching ☐mucus ☐throat clearing ☐hoarseness ☐bad breath ☐swelling

Resp: ☐cough (worse in the ☐AM ☐PM ☐all day) ☐night time awakening from cough: # _____

☐cough is worse with laughter ☐cough is worse with lying down ☐wheezing _____

year of last chest x-ray _____ Results:_____

CV: ☐chest tightness ☐shortness of breath at rest ☐shortness of breath with exertion ☐chest pain

GI: ☐hearburn/reflux (worse in the ☐AM ☐PM ☐after meals ☐all day ☐makes the cough worse)

☐hiatal hernia ☐nausea ☐vomiting ☐diarrhea ☐constipation ☐pain _____

Skin: ☐eczema ☐rash ☐hives ☐swelling ☐itching ☐dry skin _____

Stings: ☐insect reactions to: ☐bees ☐wasps ☐hornets ☐fire ants ☐mosquitoes ☐chiggers

☐reaction: ☐large local reactions ☐hives ☐wheezing ☐throat swelling ☐nausea/diarrhea

☐unconsciousness ☐emergency treatment ☐age at time of reaction_____

☐other history of anaphylaxis ☐age at time of reaction _____

Imm: ☐facial rash ☐mouth ulcers ☐nose ulcers ☐easy bruising ☐sun sensitivity ☐cold sensitivity

☐recurrent infections (☐ear ☐sinus ☐throat ☐chest ☐skin ☐urinary tract) _____

☐how many infections in the last year_____ ☐how many courses of antibiotics in the last year_____

MS: ☐joint pain ☐joint swelling ☐muscle pains ☐muscle weakness ☐muscle wasting ☐leg swelling

Endo: ☐weight gain ☐weight loss ☐amount of weight change_____in how long _____

☐hot flashes ☐hair loss ☐hot flashes ☐hair loss ☐goiter ☐miscarriages _____

☐irregular menses ☐post-menopausal ☐nursing ☐pregnancy ☐planning pregnancy, when _____

GU: ☐blood in the urine ☐painful urination ☐incontinence ☐increased urination ☐night-time urination

Past Medical History:

Immunizations: ☐Tetanus/DPT, year _____ ☐Seasonal flu, year _____ ☐ Pneumonia, year _____
☐Up to date on childhood vaccinations
☐Reactions to immunizations

Major Illnesses: _____

_____

_____

_____

Surgical History: _____

_____

_____

_____

Family Health History:

☐ Asthma ☐Hayfever or allergies ☐Eczema ☐Hives ☐Food allergy ☐Insect allergy ☐Medication allergy
☐Hives ☐Thyroid disease ☐Angioedema/swelling
☐Autoimmune disease, which: _____
☐Recurrent infections, what kind:_____
☐Heart ☐Lung disease ☐Diabetes ☐Stroke ☐Miscarriages ☐Cancer
Mother: _____ ☐Deseased ☐Alive
Father: _____ ☐Deseased ☐Alive
Siblings: _____

_____

Children: _____

_____

Social History: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated
☐Occupation: _____ ☐Retired ☐Disabled, reason_____
☐Prior occupations:_____
☐Hobbies/crafts:_____
Tobacco use: ☐Cigarettes, packs per day_____, for how many years_____
☐When did you quit? _____ ☐Smokers in the home
☐Smokeless tobacco ☐Cigars ☐Smokers in the home
Alcohol use: ☐None ☐Rare/Occasionally ☐Weekly, # per week ____ ☐Daily, # of per day ____
Illicit drug use: ☐Past, type_____ ☐Current, type_____

Diet: **Do any foods bother you, if so, which:** _____

Do you eat: ☐chocolate ☐bananas ☐nuts ☐peppermint ☐fatty foods ☐tomato products ☐citrus

☐Do you eat 2-3 hours before bed ☐do you drink large glasses of water or fluid before bed

☐Caffeine intake: ☐coffee (cups per day_____) ☐soda (# per day_____)

☐New foods

Medication allergies/intolerances:

Medication	Year	Reaction
1)		
2)		
3)		
4)		
5)		
6)		

Environmental History:

Home: ☐Townhouse ☐Apartment ☐House (age yrs, occupied for_____ yrs) ☐City/suburban ☐Rural/Farm

Basement is: ☐dry ☐damp ☐musty ☐finished ☐dehumidifier in use ☐Crawlspace ☐Slab home

Windows are open during: ☐Spring ☐Summer ☐Fall ☐Winter ☐never

Attic fan is used in the: ☐Spring ☐Summer ☐Fall ☐Winter ☐never ☐makes symptoms worse

Heating is: ☐natural gas ☐electric ☐wood ☐other _____

Humidifier is: ☐attached to the furnace ☐free standing (location _____)

Air conditioning is: ☐central ☐window unit ☐makes symptoms better ☐no air conditioning

Air filter is: ☐disposable (how often is it changed?_____) ☐HEPA filter ☐electronic ☐electrostatic

Bedroom: Location - ☐above ground ☐in the basement Flooring - ☐wall-to-wall carpeting ☐hardwood ☐area rug

Pillow: ☐feather ☐synthetic ☐new ☐old (how old?_____) ☐dust proof/allergy cover

Mattress: ☐standard ☐waterbed ☐new ☐old (how old? _____) ☐dust proof/allergy cover

Bedding: washed ☐weekly ☐monthly ☐in hot water ☐in warm water ☐in cold water

Pets: ☐Cats (number _____ ☐indoor ☐outdoor) ☐Dogs (number _____ ☐indoor ☐outdoor)

☐Birds ☐Rabbits ☐Guinea pigs/Hamsters ☐Horses ☐Other _____

Where do your pets sleep?_____ Do they have access to your bedroom? _____

Eye/Nasal symptoms are worsened by: ☐smoke ☐aerosols ☐dust ☐perfumes ☐basements ☐cats ☐dogs

☐cold air ☐wind ☐beer/wine ☐temperature changes ☐humidity ☐rain ☐season changes

☐heartburn/reflux ☐others _____

Lung symptoms are worsened by: ☐smoke ☐aerosols ☐dust ☐perfumes ☐basements ☐cats ☐dogs

☐cold air ☐wind ☐beer/wine ☐temperature changes ☐humidity ☐rain ☐season changes

☐activity ☐respiratory infections ☐laughing ☐aspirin products ☐heartburn

☐others_____

Skin History (Hives and/or rash and/or swelling/angioedema:

Features: Date of onset: _____ Worse in: ☐AM ☐PM ☐after meals ☐all day

☐Itching present – affected areas: ☐hands ☐arms ☐feet ☐legs ☐stomach ☐back ☐head/face

Appearance: ☐red ☐flat ☐raised ☐blistery ☐leaves marks/bruises ☐hives/rash moves around

☐hives stay in one spot ☐how long does the rash or hives last for? _____

Triggers: ☐heat ☐exercise ☐sunlight ☐cold ☐water ☐pressure ☐vibration ☐rubbing/scratching

☐menstrual cycle ☐stress ☐foods _____

☐poison ivy/oak/sumac ☐cut grass ☐leaves ☐plants ☐cosmetics ☐soaps ☐wool

☐others_____

Hygiene: Soap: _____ Shampoo: _____ Conditioner: _____

Detergent: _____ Fabric softener: _____

Toothpaste: _____ Cosmetics: _____

Perfumes: _____ ☐Any recent changes

Other pertinent information: