

NAME: _____

WESTSIDE ALLERGY CARE

DATE: _____

Adult/Child Allergy/Asthma Recheck Questionnaire

Has there been a change in insurance, address or phone?

Yes / No

My (my child's) Primary Care Physician is: _____

At today's visit, will you need:

- 1. Refills? /
- 2. Are there any new health problems? /
- 3. Changes in your (your child's) allergies? /
- 4. Anything else?

List your (your child's) symptoms: (√) check those that apply:

Nose stuffy/plugged	severe/daily	Moderate/ some days	Mild/Absent
Sneezing			
Itchy Watery Eyes			
Runny nose			
Post-nasal drip			
Headache			
Cough			
Wheeze			
Shortness of breath			
Rash			
Dry skin			
Welts on skin			
Food reactions			

Yes/No

- 5. Do you/ your child take medication daily for Allergies/Asthma? /
- 6. Do you sometimes forget your/ your child's daily medication? (Circle).
Often? Sometimes? Never?
- 7. How well do you feel your /your child's allergy symptoms controlled? (circle)
Excellent Good Fair Poor

8. Check your/ your child's triggers: (check all that apply)

- Animals
List all pets indoors: _____
List all pets outdoors: _____
- Pollen Do you use air conditioning? _____ Are bedroom windows Open? _____ Closed? _____
- Dust Are pillows and mattresses encased? _____ Is bedding washed weekly in hot water? _____
- Exertion Use inhaler before exertion? _____
- Odors/Irritants Air purifier? _____ Humidifier? _____ Dehumidifier? _____
- Mold/Mildew Where are you exposed to mildew? Work ___ Home _____ Outdoors _____
- Smoke List all smokers in household: _____
- Respiratory Infections:
Annual flu shot? Yes ___ No ___ If not, why not? _____
Hand washing/sanitizer? Yes _____ No _____
- Weather Change