

Westside Allergy Care, P.C.

New Patient Questionnaire

Please be sure to fill out both sides before you come to your visit

Name: _____ Date: _____ Time: _____

How did you hear about our office? _____

Reason for today's visit: _____

Does anyone else in your family have this problem? List: Father: F, Mother, M, Sister, S, Brother, B, Uncle: U, Aunt: A, Grandparent: GP/GF etc

Family History: *Indicate which family members have the conditions listed in the box below.*

Nasal allergies(Hay fever)	Asthma	Hives	Eczema or skin allergies
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Frequent Sinus infections	Bronchitis	Headaches	Food allergy-describe
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List any **foods** you are allergic to: _____

List any **medications** that you are allergic to: _____

Are you allergic to **beestings**? _____

Have you ever seen an Allergist before? _____ If so, when? _____

Causes of symptoms: S =sneeze, I =itch, R =nose runs, W =wheeze, C =cough, H =hives, N =nose congestion, HA =headache, PND =post nasal drip (List below)

House Dust:	Damp Basements:
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Vacuuming/sweeping:	Molds/Mildew:
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Cats:	Cold Air:
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Dogs:	Wind:
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Mowing:	Exercise/running:
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Smoke:	Aerosol sprays:
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Odors:	Seasons: Spring:	Summer:	Fall:	Winter:
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Medicines tried (*for allergies*): _____

Home Environment:

Age of your home: _____ How long have you lived there? _____

List the pets that are indoors: _____ Are pets allowed in the bedroom? _____

Heating: Radiators/Baseboard? _____ Hot air blows/Forced Air? _____ Woodstove? _____

Cooling: Bedroom windows open at night? _____ Fans in windows? _____ Air Conditioning? _____

Smoking: How many family members smoke? _____

Air Purifiers: Are there any air cleaner units? (in addition to the furnace filter)

Carpeting: (circle) Wall to wall carpeting. Area rugs. Bare floors.

List rooms which **Do not have Carpet:** (except for bath and kitchen)?

Basement: Damp? _____ Dehumidifier: _____ Odor or mildew? _____

Bedroom:

Age of mattress: _____ Do you use allergy encasements? _____

Do you have feather pillows or down comforters on the bed? _____

Are there stuffed animals in the bedroom? _____ On the bed? _____

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What is your current occupation? _____
Do you work around any odors/chemicals/dust? Are symptoms affected by work?
What is your marital status? (circle) Single Married Divorced/separated Widowed
Do you smoke cigarettes? (Yes/No) How many per day? For how many years?
Are you considering quitting?
Do you drink alcohol? (Circle) No Less than 2 drinks a week Less than 2
drinks 3 or fewer times a week: More than 2 drinks/more than 3 times a week:

Past History:
Are you under treatment for any of the following? (Circle) _____
Loss/gain of weight Chronic fatigue: Fibromyalgia:
Nerves: (Anxiety/Depression) Antibiotic treatment for an infection
Heart disease: High blood pressure: Diabetes:
High cholesterol: Thyroid condition:

List the names of treating physicians for conditions above: _____

Do you have: (circle) Frequent Headaches?
Gerd: (Heartburn) Arthritis? Trouble Sleeping? Irritable Bowel?

Have you ever had? (circle)
Steroid treatment: An inhaler prescribed Tubes in the ears: Sinus surgery
Bronchitis: Pneumonia Frequent ear or sinus infections
Cancer: Yellow jaundice Treatment for a nervous condition
Positive HIV or Tuberculosis test? More than 14 days out of work/school for illness?
Treatment in an emergency room for a medical condition (not an injury)
Recent blood work Recent x-rays: (if so, why)

Thank you for taking the time to fill out this questionnaire.
Please bring the completed form to your appointment.

Dr: _____ Date: _____ Time: _____

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Rochester, 14626 Brockport, NY 14420 Batavia, NY 14020
723-8710 637-3910 723-8710

You will asked to fill out additional forms for insurance and consent for treatment and medical records (HIPAA) when you arrive for your visit. *Please arrive at least 15 minutes before your scheduled appointment.*

If you are unable to keep your appointment, please call us as soon as possible.

Anitha Shrikhande, M.D.
Tom Adler, M.D.
Scott Valet, M.D.
Westside Allergy Care, P.C.