Allergy & Asthma CONSULTANTS
Breathe easier with rapid allergy and asthma relief.

Creve Coeur:
711 Old Ballas Road, Suite 100
Creve Coeur, MO 63141
Phone: 314.569.0510 Fax: 314.569.1085

St. Peters:
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St. Peters, MO 63376
Phone: 314.569.0510 Fax: 314.569.1085

New Patient History

Patient's Name:_____ Age:_____
Last *First* *Middle*

Primary Care or
Referring Physician:_____
Name *Address*

Please circle Yes or No

Symptoms:		**Eye Symptoms:**	
Cough?	Yes / No	Itching?	Yes / No
Wheeze?	Yes / No	Watering?	Yes / No
Tight Chest?	Yes / No	Redness?	Yes / No
Fatigue?	Yes / No	Puffiness?	Yes / No
Shortness of breath	Yes / No		

Nasal symptoms:		**Ear Symptoms:**	
Nasal Drainage?	Yes / No	Itching?	Yes / No
Sneezing?	Yes / No	Infections?	Yes / No
Stuffy nose?	Yes / No		
Mouth Breathing?	Yes / No	**Skin Symptoms:**	
Itch of the roof of your mouth?	Yes / No	Hives?	Yes / No
Snoring?	Yes / No	Rashes?	Yes / No
Sinus Headache	Yes / No	Eczema?	Yes / No

Have you had sinus infections ?: Yes / No
*If yes, how often?:*_____

Do symptoms awaken you at night? Yes / No
*If yes, which symptoms and how often?:*_____

Are you limited in your daily activities?: Yes / No

Do you miss days of work/school because of your illness?: Yes / No
*How many in the last year?:*_____

Have you gone to the emergency room because of asthma /allergy episodes?: Yes / No

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Allergy/Asthma Triggers

Which of the following trigger your symptoms?

Certain times of the year?	Yes / No	*If yes, Which Times?:* _____
Open windows?	Yes / No	
Animals?	Yes / No	*If yes, Which Ones?:* _____
Cutting Grass?	Yes / No	
Foods?	Yes / No	*If yes, Which Ones?:* _____
House dust/vacuuming?	Yes / No	
Damp, musty areas?	Yes / No	
Cold air?	Yes / No	
Exercise?	Yes / No	

Irritants (Perfumes, Aerosol Ssprays, Etc.)? Yes / No

Medical/Allergy Testing

Have you ever had:

Chest X-Ray: Yes / No
If yes, date of most recent X-Ray: _____ *Where was test done?* _____
Results: _____

Sinus X-Ray or CAT Scan of sinuses? Yes / No
If yes, date? _____ *Where was test done?* _____
Results: _____

Allergy Testing? Yes / No
If yes, date of most recent test: _____ *Where was test done?* _____
Results: _____

Have you ever taken allergy shots? Yes / No
If yes, how long? _____ *When?* _____

Pulmonary Function Testing? Yes / No
If yes, date of most recent test: _____ *Where was test done?* _____
Results: _____

List your current allergy/asthma medications, including over-the-counter medications:

Medication	*Dose*	*How Often*

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List your other medications, including over-the-counter medications:

Medication	*Dose*	*How Often*

Have you ever taken prednisone, cortisone, or other steroids (by mouth)? Yes / No

Are you allergic or sensitive to any medications? Yes / No
*If yes, which ones?*_____

Family History

Do other family members have asthma, sinus problems, or frequent infections? Yes / No
*If yes, who?*_____

Pregnancy
Are you currently pregnant? Yes / No *Not applicable (if male, postmenopausal, or child)*
Are you planning a pregnancy? Yes / No

Smoking
Do you currently smoke? Yes / No
Have you smoked in the past? Yes / No
*If yes, for how many years?*_____ *How much a day?*_____*When did you quit?*_____
Does anyone in your home smoke? Yes / No
Do you drink alcoholic beverages? Yes/No
*If yes, how many drinks per day?*_____

Type of Home:

_____Single family Dwelling Age of home:_____
_____Apartment
_____Condo
_____Mobile Home

Is there a basement? Yes / No

If yes, is it?: __ *Always dry* __ *Rarely leaky* __ *Frequently leaky*

Does your basement smell damp or musty? Yes / No

If no basement, is there a? _____*Concrete slab* _____*Crawlspace*

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Heat/AC:

Air Conditioning? Yes / No _____Window Unit _____Central

Heat? Yes / No _____Gas _____Electrical _____Radiant _____Wood

Humidifier on furnace: Yes / No

Do you use a fireplace or wood -burning stove: Yes/No
*If yes, how often:*_____

Do you open windows in mild weather: Yes / No

Do you have an attic fan: Yes / No

Bedroom:
Location of bedroom: ___Basement ___Ground floor ___Second floor or above

Floor cover in bedroom: ___Carpet ___Tile ___Hardwood ___Linoleum ___Other

If carpet, how old?_____months/years Composition, if know:_____

Stuffed animals in bedroom: Yes / No
*If yes, how many?:*_____

Mattress:
___Waterbed ___Conventional/Fiber-Filled
Fiber content:_____ Age:_____months/years

Pillows:
Fiber content: ___Polyester-filled ___Feather/down ___Foam rubber

Age of pillow? _____months/years

Do you have a down comforter? Yes / No

Animals/Pets: Yes / No
*If yes, kind(s) indoor:*_____

*If yes, kind(s) outdoor:*_____

*How long have you had the animal(s):*_____

House Plants: Yes / No

*If yes, how many and type?*_____

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Medical History

Have you ever had:

Bronchitis:	Yes / No	Blood disease:	Yes / No
Pneumonia:	Yes / No	Anemia:	Yes / No
Emphysema:	Yes / No	Osteoporosis:	Yes / No
Exposure to tuberculosis:	Yes / No	Bone fractures:	Yes / No
Positive TB skin test:	Yes / No	Stomach problems:	Yes / No
Other lung disease:	Yes / No	Ulcers:	Yes / No
Heart Problems:	Yes / No	Hernias:	Yes / No
Heart Attack:	Yes / No	Eye problems:	Yes / No
High blood pressure:	Yes / No	Cataracts:	Yes / No
High Cholesterol:	Yes / No	Glaucoma:	Yes / No
Diabetes:	Yes / No	Seizures:	Yes / No
Kidney disease:	Yes / No	Have you ever needed oxygen:	Yes / No
Liver disease:	Yes / No	Have you ever stopped breathing:	Yes / No
Cancer:	Yes / No		

Have you ever been hospitalized: Yes / No

If yes, give reason and dates:

Reason for Hospitalization:	*Dates:*

Have you ever had surgery: Yes / No

If so, give reasons/procedures, dates:

Reasons	*Procedure/s:*	*Dates:*

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Pediatric Patients Only

Length of pregnancy? _____months

Were there problems during pregnancy, delivery, or newborn period: Yes / No

If yes, please explain:_____

Birth weight:_____lbs. ____oz.

Has your child had chicken pox: Yes / No
Has your child had RSV: Yes / No
Are your child's immunizations up to date: Yes / No

Dr. Onder and Allergy and Asthma Consultants, P.C. conduct clinical research studies on new allergy and asthma medications. Would you be interested in you or your child participating in studies of new medications?
Yes_____ No_____ Maybe_____

Please do not write below this line

ROS:_____

P.E._____

HT._____ WT._____ B.P._____

Appearance: WNWD _____ Other:_____

Eyes:_____

L.N. _____ Ears:_____ Nares:_____

Lungs:_____

C.V.: _____ Skin: _____

A/P: _____