Anita Shvarts, M.D.
85 Seasons Lane
Hiawassee, GA 30546
[p] 855.656.6673
[f] 877.811.4836

Allergy/Immunology Questionnaire

Please take a moment to complete this form. It will help the practitioner better understand your symptoms and history from your perspective. Complete all that apply to your history.

PLEASE BEGIN BY WRITING THE PATIENT'S NAME AND DATE ON EVERY PAGE

Date: ________________ Date of Visit: __________________

Patient Name: ________________________ ❒ Female ❒ Male Age: ______ Date of Birth:__________________

The main reason for your evaluation: ____

Referred by: ________________________________ Drug Allergies:______________________________

Primary Care Physician: ______________________ Food Allergies:______________________________

Other Physicians you see and their specialties: ________________________ ________________________

List all of your current medications, including over-the-counter, vitamins and herbs	***For office use only***
Allergy/Asthma Medications ______________________ ______________________ ______________________ All other Medications ______________________ ______________________ Over the Counter Medications ______________________ ______________________ Vitamins/Supplements ______________________ ______________________	
Allergic/ Immunologic Diseases (Check all that apply) ❒ asthma ❒ rhinitis ❒ seasonal hay fever ❒ sinusitis ❒ food allergies ❒ drug allergies ❒ hives ❒ suspected/known immunodeficiency ❒ eczema ❒ insect allergy ❒ swelling episodes ❒ suspected mold exposure illness ❒ other: ______________________	

Patient Name: ____ Date: _____________________

Check all Symptoms that apply	*For office use only*
Eyes: ❒ itchy ❒ red ❒ watery Contact lenses: ❒ yes ❒ no **Nose**: ❒ nasal congestion ❒ post nasal drip ❒ runny nose ❒ sneezing ❒ nasal polyps ❒ nasal itch ❒ loss of smell ❒ nose bleeds snoring	
Nasal and Eye Symptom Triggers: ❒ dust ❒ fall pollen ❒ spring pollen ❒ grass ❒ weather change ❒ mold ❒ smoke ❒ dog ❒ cat ❒ odors ❒ foods ❒ work place Symptoms are: ❒ year-round ❒ seasonal Time of day symptoms are worst: ___________________________	
Itchy: ❒ nose ❒ throat ❒ inner ears **Sneezing**: ❒ more AM ❒ daytime ❒ evening ❒ all day **Sinusitis**: Treated with multiple antibiotics: ❒ yes ❒ no Responds to antibiotics: ❒ usually ❒ rarely ❒ never ❒ relapses after antibiotics Discolored drainage: ❒ chronic ❒ periodic Previous CT sinus? ❒ Yes ❒ No Do you suffer from chronic headaches? ❒ Yes ❒ No **Cough up mucus**: ❒ green ❒ yellow ❒ clear ❒ white ❒ bloody	
Previous Allery Evaluation: Have you ever had skin testing? ❒ Yes ❒ No If Yes, when: __________________ Have you ever been on allergy injections? ❒ Yes ❒ No If Yes, when: __________________	
History of Asthma: ❒ currently ❒ none ❒ as infant ❒ as child ❒ not formally diagnosed ❒ only with exercise ❒ also with exercise Hospitalized for asthma: # of times: _____ most recent: ______ (yr) ER visits for asthma: # of times: _____ most recent: ______ (yr)	
Wheezing: ❒ at rest ❒ with exertion ❒ climbing stairs ❒ walking ❒ all of above **Short of breath**: ❒ at rest ❒ with exertion ❒ both **Chest tightness**: ❒ at rest ❒ with exertion ❒ both Symptoms are: ❒ year round ❒ seasonal If seasonal: ❒ summer ❒ fall ❒ winter ❒ spring **Obvious triggers**: ❒ pollen ❒ dust ❒ cut grass ❒ damp/moldy areas ❒ cat ❒ dog ❒ colds/respiratory infections **Other triggers**: ❒ perfumes ❒ cleansers ❒ rain ❒ humidity ❒ cigarette smoke ❒ weather changes ❒ pressure/ barometric changes ❒ direct air form A/C or fan	

Patient Name: ______________________________ Date: ____________

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Number of steroid courses in past: _____ (prednisone, medrol, orapred, dose pak)	

Have you had:

Food Allergy Please list foods causing reactions/ dates:

____

Reaction: ❒ hives ❒ eczema ❒ throat swelling ❒ facial/ eye swelling

Emergency room treatment: ❒ yes ❒ no Dates:____________

Do you have an Epi-Pen: ❒ yes ❒ no

Immune History

Indicate those you have had and indicate number of episodes

❒ pneumonia #: ____ ❒ sinus infection #: ____ ❒ ear infection #: ____

❒ tubes in ear #: ____

❒ other allergic diseases: ______________________

Other Medical Conditions

❒ hypertension ❒ diabetes ❒ thyroid disease ❒ cataracts

❒ glaucoma ❒ migraines

Surgeries: ______________________

Other diseases: ______________________

____

Eczema

Area(s) affected: ______________________

Type of lotion(s) used: ______________________

Type of soap(s) used: ______________________

Type of detergent(s) used: ______________________

Medications tried for relief: ______________________

Age of onset: _____ Location: ____________

❒ disrupts sleep ❒ scratches a lot ❒ disrupts daily activities

Respond to: ❒ topical steroid cream ❒ elidel/protopic ❒ oral steroids only

Suspected foods: ______________________

Suspected environmental triggers:

____

Hives / Swelling Episodes

Do you experience hives/swelling? ❒ yes ❒ no

How often do they occur? ______________________

How long do they last? ______________________

How long have you had them? ______________________

Medications tried: ______________________

Check symptoms that apply:

❒ abdominal pain ❒ shortness of breath ❒ difficulty swallowing

Triggers for Hives: ❒ stress ❒ water ❒ exercise ❒ heat ❒ medications

❒ vibration ❒ pressure ❒ unknown

Patient Name: ______________________________ Date: ________________

Do you have a family history of swelling episodes? ❒ yes ❒ no

Describe Rash: ❒ welts small ❒ medium ❒ large

Location of rash: ______________________________

❒ facial ❒ lip ❒ throat ❒ eye ❒ generalized ❒ itchy ❒ painful

❒ burning ❒ bruising

Associated with: ❒ medications ❒ exercise ❒ stress ❒ heat ❒ cold

❒ meals specific foods: ______________________________

Medication Allergic Reactions

Suspected medication(s): ______________________________

Approx. date of reaction: ______________________________

Type of reaction: ______________________________

Reason medication was taken: ______________________________

Rash: ❒ hives (raised welts) ❒ fine dotted rash ❒ itchy

Location: ______________________________

Treated at: ❒ home ❒ emergency room ❒ urgent care

Insect Sting Reaction

Suspected insect ❒ fireant ❒ bee ❒ wasp ❒ hornet ❒ yellow jacket

Reaction: ❒ local swelling/redness only ❒ generalized hives

❒ throat swelling ❒ eye swelling ❒ face swelling ❒ loss of consciousness

Check all that apply

	Immediate				Mother's side					Father's side				
	Mother	Father	Sister	Brother	Grandmother	Grandfather	Aunt	Uncle	Cousins	Grandmother	Grandfather	Aunt	Uncle	Cousins
Asthma														
Rhinitis, Chronic (Hay fever)														
Sinusitis														
Eczema														
Food allergy														
Hives														
Immune Deficiency														
Thyroid Disease														
Lupus														
Rheumatoid Arthritis														
Cystic Fibrosis														
Medication Allergies														
Other														

For office use only

Patient Name: ____ Date: _____________________

Tell us about your home	*For office use only*
Dwelling Type: ❐ house ❐ apartment ❐ condo ❐ townhouse	___
❐ mobile home ❐ double-wide mobile home	___
How old is your home: __________ yrs/mos	___
How long have you lived here: __________ yrs/mos	___
Does your home have: ❐ slab (no basement, no crawl space)	___
❐ crawl space (that you can go under)	___
Basement: ❐ finished ❐ unfinished ❐ split level ❐ musty ❐ damp	___
❐ dry	___
Current leaks: ❐ roof ❐ basement ❐ other: ___________	___
Previously repaired leaks:_____________________ year: _________	___
Symptoms: ❐ better ❐ same ❐ worse … on vacation vs. home	___
Pets #Cats: _____ #Dogs: _____ #Birds: _____ Type: _______________	___
❐ indoors ❐ outdoors ❐ both ❐ in bedroom ❐ on bed ❐ hamsters	___
❐ aquarium locations: ______________________________	___
Flooring: ❐ carpet ❐ wood ❐ tile ❐ linoleum	___
❐ other: ____	___
Bedding: ❐ feather/down pillow ❐ feather bed ❐ feather/down comforter	___
❐ egg crate ❐ synthetic fiberfill ❐ foam rubber (solid piece)	___
Current Occupation: ____	___
Hobbies: ____	___
How long have you lived here: __________ yrs/mos	___
Are you a current smoker? ❐ yes ❐ no	___
# of packs a day: _____ # of years you have smoked: _____	___
Have you ever smoked? ❐ yes ❐ no	___
If yes, how many years did you smoke: _____	___
How many packs a day did you smoke: _____	___
When did you quit smoking? ________________	___
Any smokers in the home? ❐ inside ❐ outside	___
Daycare ❐ yes ❐ no Since what age: _____ # of children in class: _____	___

Which symptom is causing you the most difficulty that you would like to have cleared up or controlled?

____

What is your major concern about the symptoms/ diseases for which you are being evaluated today?

____

Thank you for completing your medical history form.
We look forward to helping to identify and treat your illness.
We hope your evaluation here is pleasant and informative. Please take a brief moment after your visit to fill out an office evaluation and tell us how we did. Please let us know if all of your questions and concerns are addressed by the end of your visit.

Doctor Shvarts and Staff