



Allergy, Asthma & Immunology of the Rockies, P.C.

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DIPLOMATE - THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

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711 EAST VALLEY ROAD SUITE 201A  
BASALT, COLORADO 81621

377 SYLVAN LAKE ROAD SUITE 220  
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### PATIENT INTAKE QUESTIONNAIRE

WHAT BRINGS YOU IN TODAY? \_\_\_\_\_  
\_\_\_\_\_

WERE YOU REFERRED, AND IF SO BY WHOM? \_\_\_\_\_  
\_\_\_\_\_

**ALLERGIES: (IF NO, CIRCLE AND MOVE ON TO NEXT SECTION)      NO**

- SNEEZING
- RUNNY NOSE
- NASAL CONGESTION      BOTH SIDES? \_\_\_\_\_
- POST NASAL DRIP
- BLOODY NOSE
- SENSE OF SMELL IMPAIRED
- SENSE OF TASTE IMPAIRED
- EYES: ITCHY WATERY RED SWOLLEN EYELIDS      IMPAIRED VISION      COLORED DISCHARGE
- IMPAIRMENT OF WORK OR SCHOOL?
- TRIGGERS:
  - SEASONS:    SPRING      SUMMER      FALL      WINTER      YEAR ROUND
  - ANIMALS
  - WORKING OR PLAYING OUTDOORS
  - STRONG ODORS/PERFUMES
  - DUST EXPOSURE
  - TEMPERATURE CHANGES
  - ASPIRIN INGESTION
- HISTORY OF NASAL POLYPS
- HISTORY OF DEVIATED SEPTUM
- HISTORY OF SEPTAL PERFORATION
- HISTORY OF RECURRENT SINUS INFECTIONS?
  - IF YES HOW MANY PER YEAR? \_\_\_\_\_
  - RECENT COLORED NASAL DISCHARGE? \_\_\_\_\_ COLOR \_\_\_\_\_
  - FACIAL PAIN, HEADACHES? \_\_\_\_\_
  - HISTORY OF SINUS SURGERY? \_\_\_\_\_
  - SINUS CT? \_\_\_\_\_ WHEN/WHERE? \_\_\_\_\_
- NEED FOR ORAL STEROIDS? (Eg. ORAPRED, PREDNISONE TABLETS OR SYRUP, MEDROL, STEROID INJECTIONS) How many times in the last year \_\_\_\_\_
- NASAL OBSTRUCTION
- SNORING
- DISRUPTED OR UNRESTFUL SLEEP
- DAYTIME SLEEPINESS OR NAPS
- OCCASIONALLY STOP BREATHING WITH EXCESSIVE SNORING
- PREVIOUS MEDICATIONS:
  - NASAL STEROIDS    EFFECTIVE/NOT EFFECTIVE
  - ANTIHISTAMINES EFFECTIVE/NOT EFFECTIVE
  - SINGULAIR EFFECTIVE/NOT EFFECTIVE

**CHEST AND LOWER RESPIRATORY SYMPTOMS**

- HISTORY OF ASTHMA AGE DIAGNOSED? \_\_\_\_\_
- WHEEZING
  - WHILE BREATHING OUT? IN? BOTH?
  - >2 TIMES PER WEEK AT REST DURING THE DAY
  - DAILY SYMPTOMS AT REST
  - NIGHTTIME SYMPTOMS >2 TIMES PER MONTH
  - EXERCISE INDUCED WHEEZE OR COUGH
- EPISODES OF TURNING BLUE
- HOSPITALIZED FOR ASTHMA:  
LOCATION? \_\_\_\_\_ WHEN? \_\_\_\_\_
- INTENSIVE CARE UNIT OR RESPIRATOR REQUIRED
- EMERGENCY DEPARTMENT FOR ASTHMA:  
LOCATION? \_\_\_\_\_ WHEN? \_\_\_\_\_
- FREQUENCY OF ALBUTEROL OR RESCUE INHALER  
USE? \_\_\_\_\_
- NEED FOR ORAL STEROIDS? (Eg. ORAPRED, PREDNISONE TABLETS OR SYRUP, MEDROL,  
STEROID INJECTIONS)
  - How many times in the last year \_\_\_\_\_
- MISSED SCHOOL OR WORK
  
- COUGH
  - BRINGS UP SPUTUM, AND IF SO, COLOR? \_\_\_\_\_
  - DRY NONPRODUCTIVE
  - DISRUPTS SLEEP OR WORSE AT NIGHT
  - BLOOD IN SPUTUM
  - HISTORY OF TB (TUBERCULOSIS) EXPOSURE
- ACID REFLUX SYMPTOMS
  
- TRIGGERS OF YOUR SYMPTOMS:
  - SEASONS: SPRING      SUMMER      FALL      WINTER      YEAR ROUND
  - ANIMALS
  - WORKING OR PLAYING OUTDOORS
  - STRONG ODORS/PERFUMES
  - DUST EXPOSURE
  - TEMPERATURE CHANGES
  - ASPIRIN INGESTION
  - EXERCISE
  - TOBACCO SMOKE EXPOSURE
- MEDICATIONS FOR ASTHMA?
  - ALBUTEROL/XOPENEX?
    - FREQUENCY OF USE \_\_\_\_\_

OTHERMEDICATIONS?:

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**PAST MEDICAL AND ALLERGIC HISTORY**  
**MEDICAL PROBLEMS:**

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**HOSPITALIZATIONS:**

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**ER VISITS:**

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**SURGERY:**

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**FOOD REACTIONS:**

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**LATEX:**

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**INSECT STINGS:**

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**IMMUNIZATIONS:**

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**MEDICATIONS:**

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**BETA BLOCKER OR ACE INHIBITOR FOR HIGH BLOOD PRESSURE?** \_\_\_\_\_

**DRUG ALLERGIES OR ADVERSE REACTIONS:**

\_\_\_\_\_  
\_\_\_\_\_

**ENVIRONMENTAL AND SOCIAL:**

HOME/APT ( FLOOR) STYLE: LENGTH OF OCCUPANCY

\_\_\_\_\_  
\_\_\_\_\_

HEAT (CENTRAL FORCED AIR / RADIATOR)

\_\_\_\_\_  
\_\_\_\_\_

AIR CONDITIONING (CENTRAL / WINDOW UNITS) HUMIDIFIER (CENTRAL / SEPARATE UNITS)

\_\_\_\_\_  
\_\_\_\_\_

BASEMENT (DAMP MUSTY SEEPAGE FLOODING )

\_\_\_\_\_  
\_\_\_\_\_

BEDROOM BOX SPRING / MATTRESS COVERS (YES NO)

PILLOW: FEATHER NON FEATHER COMFORTER: FEATHER NON FEATHER

FLOORING:

LIVING AREA: \_\_\_\_\_

BEDROOM: \_\_\_\_\_

BASEMENT: \_\_\_\_\_

**PETS:** DOG (s) \_\_\_\_\_ CAT(s) \_\_\_\_\_ BIRD(s) \_\_\_\_\_ OTHER:

BEDROOM PETS: \_\_\_\_\_

PREV. PETS \_\_\_\_\_

SMOKERS: \_\_\_\_\_

OCCUPATION:

\_\_\_\_\_

SMOKING: CURRENT? Yes/No Packs per day if yes? \_\_\_\_\_ Number of Years \_\_\_\_\_ PAST SMOKING HISTORY? \_\_\_\_\_

SECONDARY TOBACCO SMOKE EXPOSURE? \_\_\_\_\_

DRUG/ALCOHOL USE \_\_\_\_\_

\_\_\_\_\_

HOBBIES:

\_\_\_\_\_

**FAMILY HISTORY:**

PARENTS:

ASTHMA: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

OTHER: \_\_\_\_\_

SIBLINGS:

ASTHMA: \_\_\_\_\_

ALLERGIES: \_\_\_\_\_

OTHER: \_\_\_\_\_

OTHER:

HISTORY OF CYSTIC FIBROSIS OR OTHER LUNG DISORDERS? \_\_\_\_\_

**REVIEW OF SYSTEMS**

**General/Constitutional**    yes    no

Weight loss or gain, \_\_\_\_lbs      Fevers      Night sweats      decreased energy

**Skin:**    yes    no

Rash    itching    dryness    changes in hair growth or loss    nail changes  
Unusual appearing or large moles

**Eyes:**    yes    no    as previously discussed

Cataracts      Glaucoma      Loss of vision      blurred vision      Eye pain

**Ears/Nose/Mouth/Throat**    yes    no    as previously discussed

Headaches (location, time of onset, duration, precipitating factors), vertigo, lightheadedness, injury  
Nose bleeding  
Dental difficulties, gum bleeding, dentures  
Neck stiffness, pain, tenderness, masses in thyroid or other areas  
Difficulty swallowing      painful swallowing

**Cardiovascular**    yes    no

Chest pain      Heart palpitations      Left arm pain, numbness      Murmur  
difficulty breathing while lying flat      lower extremity swelling

**Respiratory**    yes    no    as previously discussed

Shortness of breath, wheezing, stridor, cough      respiratory infections, tuberculosis (or exposure to tuberculosis)

**Gastrointestinal**    yes    no

Abdominal pain    heartburn      nausea      vomiting      constipation      diarrhea  
abnormal stools (clay-colored, tarry, bloody, greasy, foul smelling)

**Genito-urinary**    yes    no

Increased frequency      urgency      blood in urine      prostate problems  
kidney problems

**Musculo-skeletal**    yes    no

Pain    swelling in joints    hands or legs    redness or heat of muscles or joints  
limitation of motion      muscular weakness      muscle cramps

**Neurologic/Psychiatric**    yes    no

Convulsions or seizures      Depression      Anxiety      Hyperactivity      ADHD  
Dizziness or passing out

**Endocrine**    yes    no

Thyroid disorder      heat intolerance      cold intolerance      excessive thirst/hunger

**Blood/Lymphatic**    yes    no

Swollen lymph nodes or "glands"      Easily bruise      Bloody gums or bleed easily  
history of lymphoma  
HIV testing      positive      negative      Blood transfusion

**Are you pregnant or planning pregnancy?**    yes    no