Geist Center for Allergy, Asthma and Immunology, PC
8150 Oaklandon Road, Suite 119
Indianapolis, IN 46236
Phone: 317-826-5440 Fax: 317-826-5463

New Patient Questionnaire

Name: _____ Date of Birth: _____

Reason for visit: _____

Duration of Symptoms: _____ Severity: _____
Associated Signs/Symptoms: _____
Parts of the Body Affected: _____
What makes it better: _____
What makes it worse: _____
Medications tried (please indicate which helped and which did not): _____
_____

Review of Systems

(Please check appropriate box of all that apply)

General	Now	Past	Ears	Now	Past
Fatigue	☐	☐	Hearing Loss	☐	☐
Fever	☐	☐	Earache	☐	☐
Weakness	☐	☐	Discharge	☐	☐
Weight Loss	☐	☐	Ringing	☐	☐
			Itching	☐	☐
			Fullness	☐	☐

Eyes	Now	Past	Nose	Now	Past
Blurry	☐	☐	Bleeding	☐	☐
Double Vision	☐	☐	Loss of Smell	☐	☐
Pain	☐	☐	Obstruction	☐	☐
Floaters	☐	☐	Sinus Problem	☐	☐
Itching	☐	☐	Itching	☐	☐
Excess Tearing	☐	☐	Sneezing	☐	☐
Dryness	☐	☐	Runny	☐	☐
Redness	☐	☐	Nosebleeds	☐	☐
Yellow eyes	☐	☐			

Mouth	Now	Past	Blood/Lymph	Now	Past
Bad Breath	☐	☐	Bruising	☐	☐
Ulcers	☐	☐	Bleeding Gums	☐	☐
Dental Problem	☐	☐	Bone Pain	☐	☐

Throat	Now	Past
Soreness	☐	☐
Pain Swallowing	☐	☐
Infections	☐	☐
Itching/Tickle	☐	☐
Swollen Glands	☐	☐
Tender Glands	☐	☐

Skin	Now	Past
Hives	☐	☐
Rashes	☐	☐
Dryness	☐	☐
Mole Changes	☐	☐
Sores	☐	☐
Yellow Skin	☐	☐

Head	Now	Past
Headaches	☐	☐
Injuries	☐	☐
Dizziness	☐	☐

Breast	Now	Past
Lumps	☐	☐
Pain	☐	☐
Discharge	☐	☐

Chest	Now	Past
Itching	☐	☐
Short Breath	☐	☐
Cough	☐	☐
Chest Pain	☐	☐
Wheezing	☐	☐

Genitourinary	Now	Past
Frequent Urination	☐	☐
Pain Urinating	☐	☐
Leaking Urine	☐	☐
Kidney Stones	☐	☐

Gastrointestinal	Now	Past
Abdominal Pain	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Bloody Stool	☐	☐
Black Stool	☐	☐
Heartburn	☐	☐
Hemorrhoids	☐	☐
Burping	☐	☐
Loss of Appetite	☐	☐
Changes in Stool	☐	☐

Heart	Now	Past
Cold Extremity	☐	☐
Ankle Edema	☐	☐
Murmur	☐	☐
Varicose Veins	☐	☐
Blood Clots	☐	☐
Palpitations	☐	☐
Chest Pain	☐	☐

Medical History

- ☐ **Hypertension** ☐ **Diabetes** ☐ **Glaucoma** ☐ **Depression**
- ☐ **Anxiety** ☐ **Bipolar Disorder** ☐ **Mental Health**
- ☐ **Headaches requiring preventive medication**
- ☐ **Any Joint Diseases (Please Specify): _____**
- ☐ **Any Other Autoimmune Disease (Lupus, +ANA, etc.)**
- ☐ **Other: _____**

Date of last flu shot: _____ Date of last pneumonia shot: _____

List dates of any hospitalizations and reasons: _____

_____

List dates of any ER visits and reasons: _____

_____

List dates of any surgeries and the type of surgery: _____
_____
Have you had a previous diagnosis of asthma or bronchitis (please specify): _____
If so, how many times? _____
Does it occur approximately the same time each year? _____

Previous allergy testing? ☐ Yes ☐ No

If yes, please provide the following information:
Dates of testing: _____
Positive to: _____

Previous allergy injections? ☐ Yes ☐ No

Social History

Occupation (for adult): _____
Lives with: _____

Type of home:
☐ Apartment ☐ Single Family Dwelling ☐ Condominium

Home location:
☐ City ☐ Suburb ☐ Countryside
☐ Close to body of water ☐ Close to wooded area

Year Built: _____

Home details:

	Yes	No
Mostly carpeted	☐	☐
Bedroom carpeted	☐	☐
History of floods or leaks	☐	☐

Method of heating:

	Yes	No
Forced air	☐	☐
Central air	☐	☐

Smoke Exposure ☐ Yes ☐ No
If yes, type and duration: _____

Pet exposure:

	Yes	No
Pets	☐	☐
Pets sleep in bedroom	☐	☐
Pets stay indoors	☐	☐

If yes, number of pets and type: _____

Sports/Exercise: _____
Hobbies: _____

Family History

(Please check all that apply and list appropriate family member)

	Yes	No	Family Member
Allergic Eyes	☐	☐	
Hay Fever	☐	☐	
Asthma	☐	☐	
Eczema	☐	☐	
Food Allergies	☐	☐	
Drug Allergies	☐	☐	
Insect Sting Allergy	☐	☐	
Migraines	☐	☐	
Heart Disease	☐	☐	
Lung Disease	☐	☐	
Abnormal Heart Rhythms	☐	☐	
Recurrent Infections	☐	☐	
Autoimmune Disease (thyroid, diabetes, lupus, arthritis, etc)	☐	☐	

Medications

(Please list all current medications and dosage)

Medication	Dosage