

NORTH TEXAS ASTHMA & ALLERGY CENTER
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NEW PATIENT QUESTIONNAIRE

Appointment date and time: _____

Patient Name: _____ Date of Birth _____

Primary Care Physician: _____

Who Referred You? _____

What problem(s) led you to seek this evaluation? _____

PLEASE CIRCLE ALL ANSWERS THAT APPLY:

Do you live in a: House Condo Apartment

How old is the residence? _____

Are there smokers in the residence? Yes No

Do you smoke or have a history of smoking? Yes No

If yes, how many years have you smoked? _____

If you are no longer smoking, when did you quit? _____ years ago

Are there pets in the residence? Yes No Dogs(##) _____ Cats (##) _____

Are the animals: Inside Outside Both

Are you exposed to strong odors or mold? Yes No

What is your current occupation? _____

Were you a full term birth? Yes No

Do you change the air filters in your residence? Yes No

TELL US ABOUT YOUR MEDICAL HISTORY:

Please list any serious illnesses: _____

Have you been hospitalized? Yes No

If yes, when and where were you hospitalized? _____

Have you required surgery? Yes No

If yes, when and why was the surgery required? _____

TELL US ABOUT YOUR FAMILY:

Does anyone in your family have a history of:

 Allergies(A) Asthma(AS) Sinus Disease(S) Hives(H)
Please enter one or more of the above letters in the spaces indicated

Mother _____ Father _____ Brother _____ Sister _____

Grandmother (Maternal) _____ Grandfather (Maternal) _____

Grandmother (Paternal) _____ Grandfather (Paternal) _____

Other _____

Are any of your family members currently patients of Dr. Moore's? Yes No

If yes, who? _____

ADDITIONAL MEDICAL INFORMATION:

Have you seen an allergist in the past? Yes No

If yes, who? _____ When? _____

Were you allergy tested? Yes No

If yes, what did you test positive to? _____

ADDITIONAL MEDICAL INFORMATION CONT'D:

Were you on allergy shots? Yes No

If yes, how long? _____ Did the allergy shots help? Yes No

Are you currently on allergy shots? Yes No

If yes, when did you start (year)? _____

Have you seen improvement in symptoms since starting shots?

 None Moderate Significant

When do symptoms occur?

 Seasonal (Fall Winter Spring Summer) Year round Both

What makes symptoms worse?

 Animals Dogs Cats Changes in Barometric Pressure
 Dust Emotions Exercise Grass Home
 Indoors Infection Irritants Mold Outdoors
 Rain Trees Weather Change Weeds
 Workplace Wind

Do you have Lower Respiratory problems, Asthma, Reactive Airways or Wheezing? Yes No

How old were you when these problems started? _____

Has Asthma been diagnosed? Yes No

What symptoms do you have?

 Chest tightness Wheezing Shortness of breath Cough
 Decreased exercise ability

When do symptoms occur?

Seasonal (Fall Winter Spring Summer) Year round Both

TELL US ABOUT YOUR PATTERNS:

How often are the attacks? _____ times per (week month year)

Do you have nighttime cough? Yes No

Do you miss school/work? _____ times per (week month year)

Have you had sudden severe attacks? Yes No

Urgent visits to the emergency room? Yes No

If yes, number of admissions _____

What makes symptoms worse?

Animals	Aspirin	Cat	Changes in weather
Cold Air	Dogs	Dust	Eating
Emotions	Exercise	Foods	Grasses
Home	Indoors	Infections	Irritants
Laughter	Laying Down		Menstruation
Molds	Outdoors	Rain	Smoke
Weeds	Workplace		

MEDICATIONS:

Do you have allergies to any medications, foods or insects? (Please be specific) _____

What allergy medications are you currently taking?

Antihistamines _____

Nasal Sprays _____

Other _____
MEDICATIONS CONT'D

What asthma medication are you currently taking? _____

Rescue medication:

Albuterol Maxair Xopenex Foradil Ventolin Proventil

Controller Medication:

Advair:	100/50 mcg	250/50 mcg	500/50 mcg
Pulmicort:	Respules 0.25 mg	Respules 0.5 mg	Turbuhaler
Flovent:	44mcg	110mcg	220 mcg
Singulair:	4mg	5mg	10mg
Asmanex	220mcg		

Please list any other prescription medications? _____

REVIEW OF SYSTEMS:

Please circle all of the choices that you now or have ever had as recurring or serious problems:

<u>Constitutional:</u>	Fatigue	Tired	Fever
<u>Respiratory:</u>	Shortness of breath	Wheeze	Cough
	Trouble with exercise	Tight chest	Cough at night
	Short of breath with exercise		Hard getting air in
	Nighttime cough/shortness of breath		
<u>Gastrointestinal:</u>	Heartburn/indigestion	Reflux	Vomiting
	Diarrhea	Trouble swallowing	Abdominal pain

Genitourinary: Frequent UTI's

REVIEW OF SYSTEMS CONT'D

Allergy/Immunology: Recurrent sinus infections Recurrent ear infections
Recurrent throat infections Recurrent pneumonia
Recurrent bronchitis Recurrent skin infections
Itching eyes or nose Hives Swelling

Musculoskeletal: Stiff/sore joints Muscle pain Red swollen joints

Eyes: Blurry vision Itch Tearing
Red eyes Frequent infections

Ear/Nose/Throat/Mouth: Runny nose Stuffy nose Itchy nose
Sneeze Loss of smell Post nasal drip
Snore Sore throat Popping
Drainage Frequent infections Itchy mouth
Sinus congestion Hoarseness Ringing
Bloody nose

Cardiac: Chest pain Increased heart rate Chest tightness

Neurologic: Seizures Headaches Dizziness

Skin: Dryness Itch Sores
Red Hives Swelling
Rash Frequent infections

REVIEW OF SYSTEMS CONT'D

Heme/Lymph: Unusual bleeding Unusual bruising Swollen lymph nodes

Endocrine: Weight gain Heat intolerance Constipation
 Cold intolerance Weight loss

Psych: Anxiety Depressed Stressed
 Worried

Signature of person completing this form _____

Relationship to Patient

Gerald C. Moore, M.D

William T. Nguyen, M.D.

