YASMIN BHASIN, M.D., F.A.C.A.A.I
DIPLOMATE, AMERICAN BOARD OF ALLERGY & IMMUNOLOGY
(Adults & Pediatrics)

15DUNNING ROAD, SUITE 1
MIDDLETOWN, NEW YORK 10940
Telephone (845) 343 -7211
Fax (845) 343 – 1040

27 S. FRANKLIN TPKE, SUITE 301
RAMSEY, NEW JERSEY 07446
Telephone (201) 934-- 9393
Fax (201) 934 - 9394

ALLERGY & ASTHMA QUESTIONNAIRE

Name Date of Birth Date

Briefly describe your symptoms:

How long have you had these symptoms?

Occupation? Time missed from work / school in the last year?

Does your job cause / worsen your condition? Y N

For the following questions – where applicable - place in the corresponding boxes – Y Yes N No ? – Not Sure NA – Not Applicable

Do you have any allergies or had an allergic reaction? To What?

Have you been tested for allergies? What year? Where? How were you tested?

By Whom? Have you taken any allergy shots? For what?

Have you had any pulmonary (breathing) tests? What year? By whom and Where?

How were you tested? Results-

Do you have any other active diseases? Which ones?-

Do you have a history of? –

Asthma Hives Emphysema Pneumonia Eczema Migraine Headaches

Hay Fever Bronchitis Pleurisy Lung cancer Colitis Tuberculosis

Do any of your relatives have a history of any of the above conditions?

Who and Which ones?

SMOKING Cigarettes Pipe Cigar -Year started smoking? Number of cig / day? Quit smoking? Year

HISTORY Do other member of your household smoke? Who?

MEDICATIONS Note dosage and times / day you take the medication **Drug Allergies**

List all Drug Reaction

Medications that

Your are taking.

Including those you buy / use

With out a prescription.

Are you taking your medications regularly?

ENVIRONMENT Number of years lived in present home? Is it an apartment? Mobile home Farm Other	
Pets at home? Which ones-	If on a farm – what animals are you exposed to?
Pillows – Polyester Feather / Down	**Blanket –** wool **Mattress –** Feather Hair
Floor - Carpeted	**Home Heating –** Oil / Gas Electric Coal Other
Heat Delivery – Forced Air Radiators	**Air Conditioned** Central Window Units
Humidifier -	**Stuffed Animals -** **Bookcases -** **Plants**
FOODS Are symptoms caused or made worse by foods/	Which ones?

For the following signs / symptoms – place in the corresponding boxes Y – Yes N – No ?- Not Sure NA – Not Applicable

EYE	Redness	Itching		
EARS	Popping	Fluid	Infection / Pain	
THROAT	Frequent infections	Dry mouth in the morning	Hoarseness	
NOSE	Frequent stuffiness	Discharge	Post nasal drip	
SINUSES	Blockage	Infections		
COUGH	Waking up in AM	Throughout the day	Awakened at night	
	Type – Dry / Tight	Produces Sputum	Color	
Frequency – Every morning / night		3 times a week	Once a week	Once a month
Shortness Of Breath	Age of onset?	Awakened at nigh	While resting	
	During strenuous exercise	Describe –		
	During moderate exercise	Describe –		
Wheezing / Chest Tightness	Awakened at night	Relieved by –		
	Frequency – Every morning	3 or more times a week	Once a week	Once a month
Any shortness of breath or wheezing prior to taking your scheduled medications? Yes No				

Which of the factors listed below cause or worsen your – coughing – Asthma, Nasal Symptoms
Mark C – Coughing A – Asthma N – Nasal symptom

Exercise	Smoke	Cold	Alcohol	Food
Dust	Irritants	Dampness	Stress	Cosmetics
Pets	Weather Change	Cold / Flu	Drugs	Emotion / Stress

What are your hobbies?
Have you traveled outside the country within the last year? Where?
At home – do you check your breathing with a peak flow meter? How often?
Do you maintain an asthma diary?
Hospitalizations
Emergency Room Visits
Surgeries
Latex Sensitivity Yes No
Bee Sting Reaction Local Swelling Or Generalized Reaction
Notes