NEW PATIENT QUESTIONAIRE

OKLAHOMA INSTITUTE of ALLERGY ASTHMA & IMMUNOLOGY

www.okallergy.com

Amy L. Darter, MD
Andrea Sestak, MD ,PEDIATRIC RHEUMATOLOGIST
Jessica Davis, PA-C
Rebekah Green PA-C
Jason Bellak, MD
Elisa Thompson, APRN-CNP
Katie Ellis, PA-C

Today's Date:_____/_____/_____

Patient Name _____ Date of Birth _____

Home Phone _____ Cell Phone _____ Sex F__ M__

Address: _____ City _____ State____ Zip _____

Referring Physician _____ Phone _____

Insurance Information

Insurance Company _____ ID _____

Group _____ Insured Name _____ Date of Birth _____

Medical History

Please state the primary problem you are here for today:

(If you have more than one problem to be evaluated, and the pattern of each symptom is different, then please ask for addition "front pages" to describe them.)

How long have you had this problem?

Is it getting better, getting worse, varying from day to day, or staying about the same?

Did anything seem to trigger it? (serious illness, travel, injury, puberty, anything else _____)

Does anything make it worse?

Does anything make it better?

Is there anything you tried that didn't work at all, or that worked at first then stopped working?

Does a family member have a similar condition?

Have you seen other physicians for this problem?

Physician	Specialty	Diagnosis Made	Diagnosis Ruled Out	Suggestions

Use back side of this page for additional space if needed.

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Past Medical History

Were you born prematurely, and if so, how many weeks?

Were you in the NICU or special care nursery for more than 3 days?

Any developmental delays or learning differences?

Any current medical conditions?

Condition	Medications taken	Treating Physician

Any resolved medical conditions?

Any hospitalizations?

Reason for admission	Length of stay	New diagnoses	New chronic medications started

Past Surgical History

Procedure	Circle		Date(s)
Circumcision	Yes	No	
Ear tubes	Yes	No	
Tonsilectomy	Yes	No	
Adenoidectomy	Yes	No	
Infusaport placement	Yes	No	
Infusaport removal	Yes	No	
Joint injections	Yes	No	
Other:			

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Social History

Who lives in your home?

Do you regularly stay in any other home long enough that you would take a daily medication there, for example weekend visitation with the other parent if yours are divorced?

Do you have pets, and if so what kind?
(dog, cat, rabbit, guinea pig, rat, mouse, bird [what kind ? _____], fish, turtle, gecko, iguana, snake, other _____)

Do you have any exposures to farm animals, and if so what kinds?
(horses, cows, pigs, goats, chickens, other _____)

What grade are you in?

Are you homeschooled?

Do you do any activities outside of school, such as sports, music, church, clubs, etc.?

Have you stopped any activities due to your illness?

Is there anything you would restart if you felt better?

Genetic Background

Are you adopted?

Are either of your parents adopted?

If adopted, do you know anything about the medical history of your genetic parents or grandparents?

Do you have any Native American heritage, and if so, what tribe(s) and how much?

Do you have any Turkish background?

Is there any possibility your parents or grandparents are related in any way? This can happen in cases of adoption, or if the couple came from the same small town or had the same last name before marriage, for example.

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Family History

Specify the family member(s) affected, if applicable. Check all that apply.

Condition	Parent	Sibling	Grandparent	Other
Childhood arthritis				
Adult arthritis				
Lupus				
Type 1 (usually childhood) diabetes				
Type 2 (usually adult) diabetes				
Ulcerative Colitis				
Crohn's disease				
Thyroid disease				
Hemophilia or bleeding disorder				
Genetic immune disorder				
Inflammatory eye disease				
Hereditary periodic fevers (FMF, CAPS, etc.)				
Multiple Sclerosis				
Psoriasis				
Leukemia				
Lymphoma				
Other cancer				
Hypertension				
Cataracts				
Problems with anesthesia				

Please describe any other medical conditions in family members that you believe are relevant, or give additional details that do not fit in the table above if desired.

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Dr. Andrea Sestak, Pediatric Rheumatology

Check all that apply.

General					
	No	Once a month	Once a week	Most days	Treated
Unexplained fever					
Chills					
Sweats					
Poor appetite					
Weight loss	Amount				
Weight gain	Amount				
Sleep					
	No	Once a month	Once a week	Most days	Treated
Trouble falling asleep					
Trouble staying asleep					
Trouble sleeping due to pain					
Daytime Fatigue					
Falling asleep in school					
Taking naps					
Cannot keep up with friends					
Missing school					
Eyes					
	No	Once a month	Once a week	Most days	Treated
Blurring					
Double Vision					
Irritation					
Red Eyes					
Discharge					
Eye pain					
Sensitive to light					
Wears glasses / contacts	Yes (glasses) / Yes (contacts) / No				
ENT					
	No	Once a month	Once a week	Most days	Treated
Ear infection					
Ears ringing					
Decreased hearing					
Nasal congestion					
Sore throat					
Hoarseness					
Snoring					
Change in voice					

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Heart					
	No	Once a month	Once a week	Most days	Treated
Chest pain					
Heart beating too fast					
Dizzy when standing up					
Passing out					
Blue lips/fingertips					
	never	at present	as infant	resolved	repaired
Heart murmur					
Respiratory					
	No	Once a month	Once a week	Most days	Treated
Short of breath with exercise					
Short of breath at rest					
Chronic cough					
Coughing up anything					
Painful breathing					
Asthma history					
	Never	With exercise	Seasonally	With illness	Year round
Uses rescue inhaler					
Uses daily steroid inhaler					
Uses nose spray					
Uses oral steroids					
Gastrointestinal					
	No	Once a month	Once a week	Most days	Treated
Nausea					
Vomiting					
Diarrhea					
Constipation					
Abdominal pain					
Pain worse after eating					
Pain better after eating					
Pain better after voiding					
Gas/bloating					
Heartburn					
Pain with swallowing					
Problems swallowing pills					
Black, sticky stools					
Blood in the stool					
Blood on the toilet paper					
Eyes and skin look yellow					

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Genitourinary					
	No	Once a month	Once a week	Most days	Treated
Blood in the urine					
Painful urination					
Wets the bed					
Urinates more than twice a night					
Leaves class to urinate					
Genital sores					
Started puberty?	Yes / no / not sure				
Post-pubertal Girls only					
Age at first period					
On birth control?	Yes - on pills / yes - on shots / yes - has implant / no				
	Menstrual symptoms				
	no	1-2x/year	most cycles	always	treated
Irregular periods					
Bleeds more than 7 days					
Misses school for menses					
Menstrual migraines					
Musculoskeletal					
	No	Once a month	Once a week	Most days	Treated
Joint pain					
Morning					
Evening					
Random					
Worse after exercise					
Keeps from sleeping					
Muscle pain					
Morning					
Evening					
Random					
Worse after exercise					
Keeps from sleeping					
Back pain					
Morning					
Evening					
Random					
Worse after exercise					
Keeps from sleeping					

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Musculoskeletal, continued					
	No	Once a month	Once a week	Most days	Treated
Pain worse after walking					
Pain worse after standing					
Pain worse after sitting					
Pain better after stretching					
Pain worse in bad weather					
Red joints					
Swollen joints					
Warm joints					
Heel pain					
Jaw locks					
Knee locks					
Skin					
	No	Once a month	Once a week	Most days	Treated
Eczema					
Acne					
Dandruff					
Psoriasis					
Mouth sores					
Hair loss					
Facial rash (not acne)					
Unidentified rash					
Vitiligo					
Birthmarks		Location -			
Urticaria (hives)					
Cause/trigger, if known					
Neurological					
	No	Once a month	Once a week	Most days	Treated
Headaches (any type)					
Headache with nausea					
Headache with visual aura					
Dizzy when sitting still					
Double vision					
Muscle tremors					
Weak grip					
Difficulty climbing stairs					
Staring spells					
Motor tics					
Seizures					

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Psychological					
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Depression					
Anxiety					
In counseling					
Difficulty concentrating					
Falling grades					
Getting in fights					
Skipping school					
Withdrawing from friends					
No interest in usual activities					
Cutting behavior					
Thoughts of suicide					
Attempted suicide		When?			
Counting calories					
Weighing frequently					
Hallucinations					
Endocrine					
	No	Once a month	Once a week	Most days	Treated
Colder than others					
Warmer than others					
Always hungry					
Always thirsty					
Rapid weight gain or loss		_____ pounds up / down in last ____ months			
Hematology					
		No	monthly	weekly	Most days
More than 5 bruises at a time					
Bruises larger than your palm					
Nosebleeds lasting > 20 min					
Bleeding gums					
Lymph nodes larger than a golf ball					
Allergy/Immunology					
	No	Currently	Seasonally	Only as infant	
Runny nose					
Chronic cough					
Allergy medications					
Allergy shots		When?			
Frequent ear infections		Resolved after tubes?			
Frequent strep throat		Resolved after tonsils out?			

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