MARDINEY® ASTHMA, ALLERGY & IMMUNOLOGY CENTERS

Michael Mardiney III, M.D.

ALLERGY AND IMMUNOLOGY QUESTIONNAIRE

ACCOUNT # ____________
OFFICE USE ONLY

Section 1: Patient Information

Last Name: ____________ First Name: ____________ M.I. ____ Date of Birth: ____________ Sex: M ◯ F ◯

Address: ____________ Apt. ______ City: ____________ State: ____ Zip: ______ SSN: ____________

Home Phone: ____________ Cell Phone: ____________ Work Phone: ____________ Ext. ______ Maiden Name: ____________

Occupation: ____________ Employer (If retired, Former Employer) ____________ Email: ____________

Work Address : ____________ City : ____________ State: ____ Zip: ______

Spouse's Name: ____________ DOB: ______ Occupation: ____________ Work Phone: ____________

Father's Name: ____________ DOB: ______ Occupation: ____________ Work Phone: ____________

Address: ____________ Apt. ______ City: ____________ State: ____ Zip: ______

Mother's Name: ____________ DOB: ______ Occupation: ____________ Work Phone: ____________

Address: ____________ Apt. ______ City: ____________ State ____ Zip ______

Primary Physician's Name: ____________ Primary Physician's Phone: ____________

Primary Physician's Address: ____________ City: ____________ State: ____ Zip: ______

Referring Physician's Name: ____________ Referring Physician's Phone: ____________

Referring Physician's Address: ____________ City: ____________ State: ____ Zip: ______

Section 2: Insurance Information

Insurance Company or Plan: ____________ Effective Date of Coverage: ______ Benefit Period Begins: ______ Ends: ______

Insurance I.D. # ____________ **Group / Policy #** ____________ Deductible / Copay ______ % Insurance Covers ______

Insurance's Address: ____________ City: ____________ State: ____ Zip: ______ Insurance Phone: ____________

Insured's Name: ____________ Date of Birth: ____________ Relationship to Patient: ____________

Address: ____________ Apt. ______ City: ____________ State: ____ Zip: ______ SSN: ____________

Insured's Employer: ____________ Insured's Position: ____________ Employer Phone: ____________

Is The Patient Covered By Any Additional Insurance? ☐ Yes ☐ No

Insurance Company or Plan: ____________ **Insurance I.D. #** ____________ **Group / Policy #** ____________

Insured's Name: ____________ Date of Birth: ____________ Relationship to Patient: ____________

Address: ____________ Apt. ______ City: ____________ State: ____ Zip: ______ SSN: ____________

Insured's Employer: ____________ Employer Phone: ____________

I certify that all information is complete and accurate - Sign : ____________ **Date :** ____________

1) PLEASE SUMMARIZE YOUR PROBLEM AND INDICATE HOW YOU WISH FOR US TO HELP YOU :

IN WHAT WAY DID YOU FIRST LEARN ABOUT OUR PRACTICE? PLEASE CHECK ALL THAT APPLY

- ☐ **I WAS REFERRED BY A DOCTOR** List physician : ____________
- ☐ **I WAS REFERRED BY A FRIEND** List friend : ____________
- ☐ **I FOUND YOU IN THE PHONE BOOK**
- ☐ **I FOUND YOUR WEBSITE ON THE INTERNET**
- ☐ **OTHER :** ____________

2) HOW MANY YEARS HAVE YOU HAD ANY SYMPTOMS OR PROBLEMS? ____________

3) DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS OR PROBLEMS? If so, please check the appropriate symptom numbers.

1)	☐	ITCHING OF THE EYES	27)	☐	RINGING OF THE EARS
2)	☐	TEARING OF THE EYES	28)	☐	FULLNESS OF THE EARS
3)	☐	REDNESS OF THE EYES	29)	☐	HEARING LOSS
4)	☐	DARKNESS UNDER THE EYES	30)	☐	EARACHE
5)	☐	SWELLING OF THE EYEBALL	31)	☐	DISCHARGE FROM THE EARS
6)	☐	SWELLING OF THE EYELID	32)	☐	POPPING OF THE EARS
7)	☐	NASAL ITCHING	33)	☐	DIZZINESS
8)	☐	RUNNY NOSE	34)	☐	HEADACHE
9)	☐	NASAL CONGESTION	35)	☐	SINUS INFECTION
10)	☐	SNEEZING	36)	☐	FACIAL PAIN
11)	☐	POSTNASAL DRIP	37)	☐	TIGHTNESS IN THE CHEST
12)	☐	NOSEBLEED	38)	☐	WHEEZING
13)	☐	LOSS OF SMELL	39)	☐	SHORTNESS OF BREATH
14)	☐	LOSS OF TASTE	40)	☐	AWAKING SHORT OF BREATH
15)	☐	SNORING	41)	☐	SINGLE OR REPETITIVE COUGH
16)	☐	BAD BREATH	42)	☐	ITCHING OF THE SKIN
17)	☐	MOUTH BREATHING	43)	☐	FREQUENT SCRATCHING
18)	☐	FREQUENT SORE THROAT	44)	☐	HIVES
19)	☐	SORE / CHANGE IN TONGUE	45)	☐	SKIN RASH
20)	☐	DIFFICULTY SLEEPING	46)	☐	ECZEMA
21)	☐	HOARSENESS	47)	☐	BOILS
22)	☐	LOSS OF VOICE QUALITY	48)	☐	POISON IVY
23)	☐	CLEARING OF THE THROAT	49)	☐	ABDOMINAL PAIN
24)	☐	DIFFICULTY SWALLOWING	50)	☐	DIARRHEA
25)	☐	DIFFICULTY CHEWING	51)	☐	HEART BURN
26)	☐	ITCHING INSIDE THE EARS	52)	☐	DISCOMFORT AFTER EATING

4) PLACE AN "S" IN THE BOX (S) ADJACENT TO THE MONTH OR MONTHS IN WHICH YOUR SYMPTOMS ARE MOST SEVERE. PLACE AN X IN THE BOX (X) NEXT TO THE OTHER MONTHS THAT YOU MAY HAVE EXPERIENCED SYMPTOMS, BUT LESS SO :

☐	JANUARY	☐	MAY	☐	SEPTEMBER
☐	FEBRUARY	☐	JUNE	☐	OCTOBER
☐	MARCH	☐	JULY	☐	NOVEMBER
☐	APRIL	☐	AUGUST	☐	DECEMBER

5) IF EXPOSURE TO ANY OF THE ITEMS LISTED BELOW CAUSE SYMPTOMS OR PROBLEMS, PLEASE CHECK YES AND THEN INDICATE ALL APPLICABLE SYMPTOM NUMBERS FROM THE LIST ABOVE USING THE SPACE PROVIDED. For instance, if you experienced hives and a runny nose from Dust exposure, you would list #'s 44 & 8. Very important, please think carefully!!

A. DUST: YES ☐ NO ☐ Symptoms: ______

B. BARNS: YES ☐ NO ☐ Symptoms: ______

C. HAY: YES ☐ NO ☐ Symptoms: ______

D. LAWN MOWING: YES ☐ NO ☐ Symptoms: ______

E. COSMETICS: YES ☐ NO ☐ Symptoms: ______

F. TOBACCO SMOKE: YES ☐ NO ☐ Symptoms: ______

G. RESPIRATORY INFECTION: YES ☐ NO ☐ Symptoms: ______

H. EMOTIONAL FACTORS: YES ☐ NO ☐ Symptoms: ______

I. FATIGUE: YES ☐ NO ☐ Symptoms: ______

J. EXERCISE: YES ☐ NO ☐ Symptoms: ______

K. CLIMATE CHANGE: YES ☐ NO ☐ Symptoms: ______

L. HEAT: YES ☐ NO ☐ Symptoms: ______

M. COLD: YES ☐ NO ☐ Symptoms: ______

N. ANIMAL EXPOSURE: YES ☐ NO ☐

Animal : ______ Symptoms: ______ Animal : ______ Symptoms: ______

Animal : ______ Symptoms: ______ Animal : ______ Symptoms: ______

O. A SPECIAL ROOM IN YOUR HOME: YES ☐ NO ☐

Room : ______ Symptoms: ______ Room : ______ Symptoms: ______

Room : ______ Symptoms: ______ Room : ______ Symptoms: ______

P. INSECT STING OR BITE: YES ☐ NO ☐

Insect: ______ Symptoms: ______ Insect: ______ Symptoms: ______

Q. FOODS: YES ☐ NO ☐

Food: ______ Symptoms: ______ Food: ______ Symptoms: ______

Food: ______ Symptoms: ______ Food: ______ Symptoms: ______

Food: ______ Symptoms: ______ Food: ______ Symptoms: ______

R. ANY OTHER AGENT OR PLACE: YES ☐ NO ☐

Describe: ______ Symptoms: ______ Describe: ______ Symptoms: ______

Describe: ______ Symptoms: ______ Describe: ______ Symptoms: ______

6) WHAT TYPE OF DWELLING DO YOU LIVE IN? ☐ Separate Home ☐ Row/Townhome ☐ Apartment

Structure: ☐ Brick ☐ Wood ☐ Stone ☐ Other Describe: ______

Source of Heat: ☐ Gas ☐ Oil ☐ Electric ☐ Hot Water ☐ Forced Air **Air Conditioned:** ☐ Yes ☐ No

Air Cleaner: ☐ Yes ☐ No **Humidifier:** ☐ Yes ☐ No What is the age of your home? ______ years

7) WHAT TYPE OF PILLOW DO YOU SLEEP ON? (examples: Cotton, Feather, Down, Polyester, Hypodown, Memory Foam, Wool, Other)

Pillow : ______ Do you use an Allergy Cover? ☐ Yes ☐ No

8) WHAT TYPE OF MATTRESS DO YOU SLEEP ON? (examples: Cotton, Memory Foam, Vinyl (airbed / waterbed), Other)

Mattress : ______ Do you use an Allergy Cover? ☐ Yes ☐ No

9) DO YOU HAVE RUGS IN YOUR HOME? ☐ Yes ☐ No If yes, please list what they are made of, and their location(s):

Rugs : ______

10) HAVE YOU EVER SMOKED? ☐ Yes ☐ No How many packs per day? ______ **DO YOU CURRENTLY SMOKE?** ☐ Yes ☐ No

FORMER SMOKERS : HOW LONG HAS IT BEEN SINCE YOU QUIT? ______

WHAT DID YOU/DO YOU SMOKE? (Cigarettes, Cigars, Pipe, etc..) List all that apply : ______

11) DO YOU HAVE ANY PETS? ☐ Yes ☐ No If so, please list number of each :

Dogs : ______ Cats : ______ Birds : ______ Gerbils : ______ Horses : ______ Guinea Pigs : ______

Other (Please list all) : ______

12) DO YOU HAVE, OR HAVE YOU EVER HAD, FUNGAL INFECTIONS OF THE SKIN? ☐ Yes ☐ No If yes, please describe :

Describe : ____________________

13) DO YOU SUFFER FROM DRYNESS, OILINESS, SWEATING, BLEMISHES, SKIN RASH, INCREASED OR DECREASED PIGMENTATION OR EASY BRUISING OF THE SKIN? ☐ Yes ☐ No (Please describe any and all that apply below)

Describe : ____________________

14) HAVE YOU BEEN EVALUATED BY AN ALLERGIST IN THE PAST? ☐ Yes ☐ No Were you skin tested? ☐ Yes ☐ No

Please list Name of Allergist & Date/Location of evaluation : ____________________

15) HAVE YOU HAD A CHEST X-RAY? ☐ Yes ☐ No If yes, please list the date(s) taken and the results :

X-ray date : __________ Results : ____________________

16) HAVE YOU HAD SINUS X-RAYS OR CT OF THE PARANASAL SINUS? ☐ Yes ☐ No If yes, please list the date(s) taken and the results :

Scan date : __________ Results : ____________________

17) HAVE YOU HAD ANY OTHER PERTINENT TESTING? ☐ Yes ☐ No If yes, please list date of testing and results :

List : ____________________

18) PLEASE LIST THE MEDICATIONS THAT YOU ARE TAKING. Include what you take them for, and if you find them helpful :

1: __________ 4: __________

2: __________ 5: __________

3: __________ 6: __________

19) DO YOU HAVE ANY ALLERGY TO DRUGS? (skin rash, wheezing, anaphylaxis, etc..) ☐ Yes ☐ No If yes, list the drugs and reactions :

1: __________ 3: __________

2: __________ 4: __________

20) IS THERE A FAMILY HISTORY OF ALLERGY? ☐ Yes ☐ No If yes, please list the problem and affected relative below :

1: __________ 3: __________

2: __________ 4: __________

21) ARE YOU MARRIED? ☐ Yes ☐ No **SEPARATED?** ☐ Yes ☐ No **DIVORCED?** ☐ Yes ☐ No **WIDOWED?** ☐ Yes ☐ No

22) HOW LONG HAVE YOU BEEN MARRIED? __________

23) LIST THE AGE, SEX, AND GENERAL HEALTH STATUS OF YOUR CHILDREN :

1: ____________________

2: ____________________

3: ____________________

24) LIST THE AGE, SEX, AND GENERAL HEALTH STATUS OF YOUR BROTHERS AND SISTERS :

1: ____________________

2: ____________________

3: ____________________

25) PLEASE LIST CAREFULLY ALL SERIOUS ILLNESSES AND HOSPITALIZATIONS (Medical and Surgical - Extending to infancy)

Include in this list : Diagnosis, Date of Illness, and Attending Physician name, phone number and address

1: ____________________

2: ____________________

3: ____________________

4: ____________________

5: ____________________

6: ____________________

26) HAVE YOU EVER HAD ANY OF THE FOLLOWING DISEASES? Please place a check next to the diseases that apply. In the area to the right of the disease, please list the applicable dates in MM/YYYY format (05/1968). If currently experiencing, list current :

☐	Disease	Dates	☐	Disease	Dates	☐	Disease	Dates
☐	C.O.P.D.		☐	Gallbladder Disease		☐	HIV / AIDS	
☐	Whooping Cough		☐	Hepatitis		☐	Fibromyalgia	
☐	Chronic Lung Disease		☐	Liver Disease		☐	Chronic Fatigue Syndrome	
☐	Kidney Disease		☐	Jaundice		☐	Osteoarthritis	
☐	Sleep Apnea		☐	Measles		☐	Osteopenia / Osteoporosis	
☐	Anemia		☐	Chicken Pox		☐	Rheumatoid Arthritis	
☐	Tonsillitis		☐	Diphtheria		☐	Lupus	
☐	Cancer		☐	Lyme Disease		☐	High Blood Pressure	
☐	Celiac Disease		☐	Tropical Disease		☐	Elevated Cholesterol	
☐	Peptic Ulcer		☐	Venereal Disease		☐	Heart Surgery	
☐	Inflammatory Bowel Disease		☐	Mumps		☐	Cardiac Arrhythmia	
☐	Irritable Bowel Syndrome		☐	Tuberculosis		☐	Thyroid Disease	
☐	Gastroesophageal Reflux		☐	Rheumatic Fever		☐	Diabetes Mellitus	

Please list any other disease not found above (include date) : ____________________

27) ARE YOUR GRANDPARENTS AND/OR PARENTS STILL ALIVE? ☐ Yes ☐ No
If they are not, what did they die from? If alive, please list their ages:

Mother : ____________ Mother's Mother : ____________ Mother's Father : ____________

Father : ____________ Father's Mother : ____________ Father's Father : ____________

28) HAS ANYONE IN YOUR FAMILY EVER HAD ANY OF THE FOLLOWING DISEASES? if so list which, and who had it :

CANCER, DIABETES, ARTHRITIS, RHEUMATIC FEVER, HEART ATTACK, STROKE, TUBERCULOSIS, COLITIS, GOUT, ULCERS, HIGH BLOOD PRESSURE, EPILEPSY, LEUKEMIA, ULCERS, ANEMIA, KIDNEY DISEASE, AUTOIMMUNE DISEASE, OR ANY OTHER HEREDITARY OR GENETIC DISEASE :

1: ____________ 4: ____________

2: ____________ 5: ____________

3: ____________ 6: ____________

29) DO YOU DRINK A GREAT DEAL OF LIQUID? ☐ Yes ☐ No
DO YOU DRINK ALCOHOL? ☐ Yes ☐ No What is your average weekly alcohol consumption? ____________

30) HAVE YOU GAINED OR LOST WEIGHT OVER THE PAST SEVERAL MONTHS? ☐ Yes ☐ No

List your average weight and comment on if it has increased or decreased : ____________

What is your height? ____________ Has there been any recent change? ☐ Yes ☐ No

What is your weight? ____________ Has there been any recent change? ☐ Yes ☐ No

Do you have a good appetite? ☐ Yes ☐ No

31) DO YOU SUFFER FROM FEVER, CHILLS, CHILLINESS, OR NIGHT SWEATS? ☐ Yes ☐ No

If so, Explain : ____________

32) IS YOUR VISION NORMAL? ☐ Yes ☐ No **Do you wear :** ☐ Glasses ☐ Contact Lenses
Do you suffer from : ☐ Color Blindness ☐ Night Blindness ☐ Puffy Eyelids ☐ Blurred Vision

33) DO YOU HEAR WELL? ☐ Yes ☐ No **DO YOU WEAR A HEARING AID?** ☐ Yes ☐ No

34) DO YOU HAVE ABDOMINAL PAIN BEFORE OR AFTER EATING? ☐ Yes ☐ No

35) HAVE YOU EVER VOMITED BLOOD? ☐ Yes ☐ No

36) DO YOU USE LAXITIVES? ☐ Yes ☐ No

37) DO YOU HAVE HEMORRHOIDS? ☐ Yes ☐ No

38) HAVE YOU EVER HAD BLOOD IN YOUR BOWEL MOVEMENTS? ☐ Yes ☐ No

If so, please state when : ____________

39) HAVE YOU EVER EXPERIENCED BURNING DURING URINATION? ☐ Yes ☐ No

40) HAVE YOU NOTICED AN INCREASE OR DECREASE IN UNDERARM OR PUBIC HAIR? ☐ Yes ☐ No

If so, please describe the appropriate problem : ____________

41) HAS THERE BEEN AN INCREASE IN THE SIZE OF YOUR EYES, NECK, CHANGES IN HEAT TOLERANCE, DIFFICULTY IN KEEPING HAIR WAVE, OR CHANGE IN YOUR SPEAKING AND/OR SINGING VOICE? ☐ Yes ☐ No

List all that apply : ____________

42) DO YOU SUFFER FROM FREQUENT TEETH OR GUM PROBLEMS? ☐ Yes ☐ No

43) DO YOU SUFFER FROM ENLARGEMENT OF THE NECK? ☐ Yes ☐ No

44) DO YOU SUFFER FROM LUMPS, PAIN, DISCHARGE, OR CHANGE FROM THE NIPPLES? ☐ Yes ☐ No

List all that apply : ____________

45) DO YOU SUFFER FROM CHEST PAIN, COUGH, SPITTING UP OF BLOOD, EXTREME SHORTNESS OF BREATH, PALPITATIONS, MISSED HEART BEATS, AND/OR SWELLING OF THE ANKLES? ☐ Yes ☐ No

List all that apply : ____________

46) DO YOU HAVE A HEART MURMUR? ☐ Yes ☐ No

47) DO YOU SUFFER FROM : ☐ Muscle Cramps ☐ Numbness ☐ Tingling of the Hands or Feet

48) DO YOU SUFFER FROM JOINT PAIN? ☐ Yes ☐ No

If yes, please list all joints affected : ____________

49) DO YOU SUFFER FROM BACKACHES? ☐ Yes ☐ No

50) DO YOU SUFFER FROM : ☐ Varicose Veins ☐ Flat Feet ☐ Ulcers of the Feet

51) FEMALES ONLY - PLEASE LIST AGE OF ONSET OF PERIODS : ____________

The duration of the flow, and interval between periods : ____________

Do you use contraceptives? ☐ Yes ☐ No If so, what type? ____________

52) PLEASE LIST NUMBER OF PREGNANCIES : ____________ **PLEASE LIST NUMBER OF LIVE BIRTHS :** ____________

List chronological dates of all pregnancies : ____________

OUR LOCATIONS :
Please use mapquest for detailed driving directions to each center.

ELLICOTT CITY
3105 North Ridge Road
Ellicott City, MD 21043
Phone : 410-461-7660

OVERLEA
7602 Belair Road
Baltimore, MD 21236
Phone : 410-663-5549

GLEN BURNIE
7927 Ritchie Highway
Glen Burnie, MD 21061
Phone : 410-760-1300

LUTHERVILLE
1734 York Road
Lutherville, MD 21093
Phone : 410-561-4488

WESTMINSTER
215Washington Heights
Medical Center
Westminster, MD 21157
Phone : 410-871-0080