Staple

BRIGHAM AND WOMEN'S HOSPITAL

75 Francis Street, Boston, Massachusetts 02115

PATIENT IDENTIFICATION AREA

Aspirin Exacerbated Respiratory Disease (AERD)/ Samter's Triad Patient Questionnaire

Patient Name: Date Of Birth: Today's Date:

Address:

Occupation:

Telephone: Home: Cell: Work:

Name of referring physician:

Address of referring physician:

What other health care providers have you seen? (Include provider's name and specialty)

ALL PATIENTS MUST BRING AN UP-TO-DATE AND ACCURATE LIST OF ALL MEDICATIONS THEY ARE CURRENTLY USING OR HAVE TAKEN IN THE PAST 6 MONTHS (including dosages)

What are the main reasons for your visit today?:

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Do you have any of the following? (Please circle your replies)

sneezing	blocked nose or congestion	watery nose	shortness of breath
wheezing	chest tightness	cough	sputum (phlegm)
coughing at night	severe itching	severe swelling	acid stomach / heartburn
difficulty breathing	rash	chest pain	frequent fevers

Have you been told, or do you suspect you have any of the following? (Please circle your replies)

sinusitis	ear infections	nasal polyps	chronic bronchitis
eczema	hives	stomach reflux	allergic rhinitis / hay fever
pneumonia	asthma	frequent infections	hypothyroid / abnormal thyroid

During which times of year are your symptoms the worst? (Please circle your replies)

Spring Summer Fall Winter Always bad

What things make your symptoms worse? (Please circle your replies)

respiratory infections / "colds"	cold air	Allergens:
emotions – stress	exercise	animals/pets
tobacco smoke / pollution	weather changes	dust
strong odors	alcoholic beverages	pollens
aspirin	medicines like ibuprofen, naproxen ("NSAIDs")	mold

Other triggers: _____

_____

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Does your illness lower your ability to exercise or to do any physical activity?

Do you have any other medical problems? Please describe:

What tests have been done for you?

Test	Year of testing and Results
Allergy skin prick tests	
Allergy blood tests (RAST)	
Chest or sinus X-Ray	
Other tests	

Do you have any other Allergies?

Medication allergies (other than aspirin/NSAIDs):

Food/Food additives:

Insects (Describe reactions):

Have you ever had immunotherapy? If so, how well did it work?

Have you ever had a severe allergic reaction (anaphylaxis)?

Asthma History

Have you ever been diagnosed with asthma? Yes No Age at diagnosis:

Number of visits for asthma (lifetime) to emergency room:

Number of hospitalizations for asthma (lifetime):

History of "Life-threatening" attacks? Yes No Intubated: Yes No

Number of days you have been on oral steroids (prednisone) in past year (approximate):

Nasal Polyp History

Have you ever been diagnosed with nasal polyps? Yes No Age at diagnosis:

If so, how many lifetime polyp surgeries have you had?

If so, how long does it usually take your polyps to grow back after surgery?

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Rash History

Do you ever get episodes of an itchy rash or hives? Yes No

If so, which medications have you tried to treat the rash or hives?

Aspirin / NSAID Reaction History

Have you ever had reactions to any of the following medications? (Please circle your replies)

Aspirin (Excedrin, Alka-Seltzer)	Ibuprofen (Motrin, Advil)	Naproxen (Aleve, Anaprox)	Ketorolac (Toradol)	Acetaminophen (Tylenol)

How old were you when you first had a reaction to any of the above medications? _____

What happened to you when you had a reaction to these medications? (Circle all that apply):

Nasal congestion or runny nose	Eye watering or redness	Cough, wheezing, tightness in the chest	Nausea or stomach pain
Headache or face pain	Hives or rash	Flushing of the skin	Other: _____

Did you use any of the following treatments for your reactions? (Circle all that apply):

Antihistamines (Benadryl, Allegra, Zyrtec, Claritin)	Albuterol or other rescue inhaler	steroids taken by mouth	steroids taken through a vein	Epinephrine (EpiPen)

How long was it from the time you took the medication to the start of reaction symptoms?

less than 30 minutes 30 minutes to 3 hours more than 3 hours

Tobacco Smoking & Alcohol History

Have you ever smoked tobacco? Yes No Date stopped:

Number of years smoked: Approximate packs per day:

Have you ever lived with someone who smoked? Yes No If yes, for how long?

In which type of environment did you grow up? Rural Suburban City

Have you ever used recreational drugs (marijuana, cocaine, ecstasy, etc)? Yes No

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Do you drink alcohol: Yes No

Do you ever have any of the following when you drink alcohol (please circle):

Stuffy nose/nasal congestion Runny nose Shortness of breath Wheezing

Environmental History

What type of home do you live in? house apartment multifamily

Location of home: city suburb rural

What kind of air control and heating does the home have? (Please circle your replies):

forced hot water forced hot air humidifier room air conditioning

wood stove dehumidifier air filter central air conditioning

What type of flooring does the bedroom have? (Please circle your replies):

hardwood floors wall-to-wall carpeting area rugs tile/linoleum

Does the home have any pets? Please list.

Does anyone smoke at home? If so, who?

Family History (Please check all that apply)

	asthma	hay fever	nasal polyps	immune deficiency	aspirin sensitivity
Mother					
Father					
Siblings					
Other					

Have you had any other serious illnesses, accidents, or hospitalizations? If so, when?

Are you pregnant or planning on getting pregnant?

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Have you ever felt unsafe in the home or been afraid of anyone? Yes No

Do you feel pain as part of your daily life? Yes No

If yes, where do you feel pain? How does the pain start? How long does it last? How would you describe it?

If yes, on a scale from 1-10, 10 being the greatest pain, which number better describes this pain?

If yes, how do you treat your pain?

Have you had any unexpected weight gain or loss in the past six months? Yes No

How do you like to learn new information? ☐ Talking with your nurse or doctor ☐ Reading

Have you fallen down within the past year? Yes No

Do you have a Health Care Proxy, Advance Directive, or Living Will? Yes No

If yes, please tell us his or her name:

The information on this form is accurate to the best of my knowledge. I understand that this form will become part of my medical record.

Patient Signature: _____ _____ _____ AM/PM
Date Time

I have reviewed the above information with the patient.

Comments: _____

Reviewed by:

_____ | | | | | | _____ _____ AM/PM
MD Signature Date Time