BRIGHAM AND WOMEN'S HOSPITAL

75 Francis Street, Boston, Massachusetts 02115

PATIENT IDENTIFICATION AREA

Aspirin/NSAID Hypersensitivity Patient Questionnaire

Demographic Information:

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

Address:

Occupation:

Telephone: Home: Mobile: Work:

Email:

Gender (circle): Male Female

Ethnicity (circle): Hispanic/Latino Not Hispanic/Latino

Race (circle): White Black/African American

Asian American Indian or Alaska Native

Hawaiian Native or Pacific Islander Other_____

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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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)
Meloxicam (Mobic)	Indomethacin (Indocin)	Celecoxib (Celebrex)	Other: _____	

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

Why did you receive this medication? _____

How many total reactions have you had to aspirin or NSAIDs? (circle) 1 2 ≥3

How many years ago was your **last** reaction? _____

Since your last reaction, have you taken **and tolerated** any other NSAIDs? _____

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 / vomiting
Throat closing	Hives	Flushing of the skin	Delayed rash (not hives)
Headache / face pain	Dizziness	GI upset	Bleeding
Abnormal blood tests	Felt unwell	Fainting / low blood pressure	Other: _____

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

Antihistamines (Zyrtec, Allegra, Claritin, Benadryl)	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?

< 30 minutes 30 minutes to 3 hours > 3 hours >24 hours unknown

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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):

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?

Do you have any other allergic diseases?

Medication allergies (other than aspirin/NSAIDs):

Food/Food additives:

Insects (describe reactions):

Environmental allergies (circle): Pollens Dust Mold Animal Dander

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

Atopic dermatitis / Eczema:

Other Medical History

Do you have any of the following (circle all that apply):

Cardiovascular/heart disease	GERD/reflux/heartburn	GI bleeding
Hypertension/high blood pressure	Chronic kidney disease	Anxiety
Depression	Other_____	

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Family History (Please check all that apply)

	Asthma	Hay fever	Nasal polyps	Immune deficiency	Aspirin/NSAID sensitivity	Chronic hives/urticaria
Mother						
Father						
Siblings						
Other						

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