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 THEYARE 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? _______________

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