Please fill out fully (circle, check and / or fill in the answer)

TO BE COMPLETED BY PATIENT AND GIVEN TO MEDICAL ASSISTANT:

Name _____ Age_____ DOB _____ M/F___ Date _____

Referred by? _____ Additional Physicians_____

Reason for visit:_____

Local pharmacy of choice:_____ Mail order pharmacy:_____

MEDICATIONS

List medications taken for asthma, allergies, sinus, or skin problems. Include nasal sprays and inhalers.

Current medications:

_____ _____

_____ _____

_____ _____

_____ _____

Medication allergies:

_____

_____

_____

_____

_____

Prior allergy/asthma medications that did not help/were not tolerated:

_____

_____

YOU MAY SKIP THE REMAINDER OF THIS FORM IF YOU COMPLETED THE ONLINE HEALTH HISTORY INFORMATION

REVIEW OF SYSTEMS

Circle ALL symptoms that apply currently

General:
Unexplained weight gain
Unexplained weight loss
Unexplained fever

Neck:
Neck mass
Swollen glands

Gastrointestinal:
Abdominal pain
Bloating
Constipation
Diarrhea
Difficulty swallowing
Frequent belching
Gas
Heartburn
Indigestion
Mucousy stools
Bloody stools
Nausea
Vomiting

HEENT:
Bad taste
Loss of taste
Loss of smell
Sore throat
Voice changes

Respiratory:
Snoring
Shortness of breath

Cardiovascular:
Chest pain

Musculoskeletal:
Joint pain
Muscle pain

Neurological:
Headaches

Endocrine:
Appetite changes
Thyroid problems

PAST MEDICAL HISTORY

List all other medical conditions briefly:_____

_____

PAST SURGICAL HISTORY

List prior surgeries (with approximate dates):_____

_____

Please fill out fully (circle, check and / or fill in the answer)

YOUR BIRTH HISTORY/ INFANT FEEDING (if under 18 y.o)

Gestational Age:

Term (37-42 weeks)
Pre Term (<37 weeks)
Post Term (>42 weeks)
Complications?:_____

Delivery Mode:

Natural
C-Section

Feeding History:

Breast Fed? Y/N How many months? _____
If formula fed/supplemented, what formula base: (circle one)
Milk based
Hydrosylated
Soy based
Other:_____

SOCIAL/ ENVIRONMENTAL HISTORY

Indoor pets/animals: None Dog Cat Bird Fish Gerbil
Hamster Rabbit Reptile Rodent Other: _____

Occupation: _____

Hobbies: _____

Smoking History: _____ Never smoker _____ Prior smoker _____ Current Smoker

If you are a smoker please fill/circle the questions below:
What do you use (cigarettes, pipes, cigars, marijuana, chewing tobacco)? _____
For how many years? _____
Have you tried to quit? _____
Would you like to quit? _____ Need help? _____

Second Hand tobacco exposure:

None
Frequent
Family member smokes indoors/in car
Caregiver smokes indoors/in car
Minimal
Daily
Family member smokes outdoors only
Caregiver smokes outdoors only

FAMILY HISTORY

Do parents (m,f), grandparents (gm, gf), siblings (b,s), or children (d, son) have the following?

Asthma _____ Allergic rhinitis/Hay fever _____ Food Allergies _____
Chronic Infections/Immune def _____ Contact Dermatitis_____ Cystic Fibrosis_____
Eczema_____ Emphysema_____ Hives _____
Sinusitis _____

IMMUNIZATION HISTORY

Are immunizations/vaccines up to date? Y/N/Not Sure :_____

Please fill out fully (circle, check and / or fill in the answer)

To be completed in exam room and discussed with healthcare provider: NAME: _____
Date of Birth:_____

Circle or check symptoms that apply, or circle none:

UPPER AIRWAY SYMPTOMS

Rhinitis (nose)
- None
- Itchy nose
- Sneezing
- Runny nose
- Post nasal drip
- Throat clearing
- Nasal congestion
- Constant "cold" like symptoms
- Dry nasal membranes
- Diagnosed nasal polyps
- Loss of taste
- Loss of smell
- Itchy roof of mouth
- Sensitivity to odors

Conjunctivitis (eyes)
- None
- Itchy eyes
- Watery eyes
- Red eyes
- Puffy eyes

Sinusitis (sinuses)
- None
- Sinus pressure
- Sinus pain
- Headaches

Symptoms occur:
- Spring
- Summer
- Fall
- Winter
- All year
- With weather changes
- Randomly

How long have you had your symptoms?_____

Prior treatments (for allergy and sinus symptoms):
- None
- Steam inhalation
- Allergy shots
- Nasal saline washes
- Oral allergy medications (Zyrtec, Claritin, etc)
- Decongestant nasal sprays (Afrin)
- Other _____
- Oral decongestants (Sudafed)
- Steroid nasal spray (Flonase, Nasonex, etc)
- Leukotriene Receptor Antagonists (Singulair)
- Allergy eye drops (Pataday, Bepreve)
- Oral steroid (Prednisone, Orapred)
- Steroid shots

Are you interested in learning more about allergy shots? _____

Circle any of the following that aggravate your symptoms:
- House dust
- Vacuuming/Sweeping
- Hay/Straw/Barn/Stable
- Pollens
- Mowing the lawn/Raking leaves
- Basement/moldy areas
- Birds
- Cats
- Dogs
- Other animals _____
- Tobacco smoke
- Strong odors
- Cold air
- Humidity
- Exercise
- Exposure to chemicals
- Wood stove
- Other triggers _____

Please fill out fully (circle, check and / or fill in the answer)

LOWER AIRWAY SYMPTOMS

Symptoms:

No lower airway symptoms
Chronic cough
Night time cough
Recurrent wheezing
Shortness of breath
Chest tightness
Recurrent bronchitis
Shortness of breath with exertion/exercise
Cough with exertion/exercise
Wheezing with exertion/exercise
Have you been previously diagnosed with asthma? Y/N

How long have you had your symptoms?_____

Prior treatment for lower airway:

None
Albuterol inhaler or nebulizer
Inhaled steroids (Flovent, QVAR, etc)
Combination ICS/LABA (Advair, Symbicort, etc)
Leukotriene Receptor Antagonists (Singulair)
Oral steroids (Prednisone)
Other asthma medications: _____

Current symptom frequency:

How often do you have these symptoms? _____
If you have albuterol, how often do you use it? _____

Asthma history (if previously diagnosed with asthma):

Have you ever had (circle all that apply):

Frequent ER visits
Prior oral steroid bursts
Prior hospitalizations
Prior ICU admission
Prior intubation

GASTROINTESTINAL PROBLEMS/FOOD ALLERGIES

Any previously diagnosed/confirmed food allergies? Y/N If Yes, list foods:_____

_____

Any suspected food allergies? Y/N If Yes, list suspected foods and symptoms:_____

_____

_____

_____

_____

_____

How long have you had these symptoms? _____

Please fill out fully (circle, check and / or fill in the answer)

SKIN PROBLEMS

Any chronic or recurrent skin issues (hives, eczema, etc)? _____

_____

Where on your body do the skin problems occur:

Face
Trunk
Legs
Head
Other_____
Hands
Arms
Feet
Neck

Severity of symptoms:

Mild
Moderate
Severe
Waxing and Waning

SEVERE ALLERGIC REACTIONS

Have you ever had a life-threatening allergic reaction? Y/N

If Yes, what were your symptoms? _____

_____

What do you think caused the reaction (foods/medications/stings/etc.)? _____

_____

RECURRENT INFECTIONS

None
Recurrent ear infections? Y/N If Yes, how many per year?_____ Ear tubes required? _____
Recurrent sinusitis infections? Y/N If Yes, how many per year? _____
Recurrent pneumonias? Y/N If Yes, how many? _____
Recurrent skin infections? Y/N
Other concerning infections? (meningitis, cellulitis, abscesses, etc)?_____

OTHER SUSPECTED ALLERGIES

Latex allergies Y/N - If Yes, please list symptoms: _____

Contact allergies Y/N - If Yes, please list symptoms and trigger: _____

Any medication allergies Y/N - If Yes, please list: _____

Any reactions to biting or stinging insects Y/N – If Yes, please list: _____

Any other allergy/immune concerns today?_____

_____