

Allergy, Asthma & Immunology Center of Alaska, LLC

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

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:

REVIEW OF SYSTEMS

Circle ALL symptoms that you are having 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): _____

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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 : _____

TRAVEL HISTORY

Any travel outside the state or country in the last year? If so, where? _____

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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 All year
Summer With weather changes
Fall Randomly
Winter

How long have you had your symptoms? _____

Prior treatments (for allergy and sinus symptoms):

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

Are you interested in learning more about allergy shots? _____

Circle any of the following that aggravate your symptoms:

House dust	Tobacco smoke
Vacuuming/Sweeping	Strong odors
Hay/Straw/Barn/Stable	Cold air
Pollens	Humidity
Mowing the lawn/Raking leaves	Exercise
Basement/moldy areas	Exposure to chemicals
Birds	Wood stove
Cats	Other triggers _____
Dogs	
Other animals _____	

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LOWER AIRWAY SYMPTOMS

Symptoms:

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

How long have you had your symptoms? _____

Prior treatment for lower airway:

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

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 ICU admission |
| Prior oral steroid bursts | Prior intubation |
| Prior hospitalizations | |

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? _____

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SKIN PROBLEMS

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

Where on your body do the skin problems occur:

Face	Hands
Trunk	Arms
Legs	Feet
Head	Neck
Other _____	

Severity of symptoms:

Mild	Severe
Moderate	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? _____
