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Patient Name: _____ Date: _____
Date of Birth _____ Age: _____ Sex: _____
Ethnicity _____ Occupation: _____
Parent Name (if minor) _____

What is your chief complaint or most bothersome symptom(s)? _____

What medications have you taken in the past 5 days?

Hospital stays? For what? _____

Circle those that apply to you below.

Have you ever been diagnosed with any of the following:

*Hay Fever Asthma Pneumonia Bronchitis Hives (welts)
Eczema Insect Allergy Other (specify) _____*

Have you ever been on allergy injections? Y N

If yes, when? _____ How long? _____ Did they help? Y N

Who provided the vaccine? _____

Have you had positive skin tests to:

*Dust Mites Trees Grasses Weeds Molds Cats Dogs
Foods Feathers Other: _____*

Circle those that apply:

NOSE: *Itchy Blocked Runny Bleeding Sneezing*

EYES: *Itchy Watery Swollen Burning Red*

EARS: *Itchy Blocked Ringing Pain/Ache Hearing Loss*

SINUSES: *Stuffy Headaches Infections Drip & Throat Clearing
Cough*

CHEST: *Cough/Wheezing Palpitation Tightness Cough with Exercise
Chest Colds Cough lying down Breathless Pain*

SKIN: *Itchy Dry Hives Eczema Swelling Rashes*

OTHER: *Loss of Smell Nasal Polyps Itchy Mouth
Itchy Throat Infections*

Please list all current medications: _____

When are your symptoms worst?

Spring Summer Fall Winter Year-Round At Home At Work Both

Does exposure to any of the following aggravate your symptoms?

*Dust Molds Leaves Cold Air Smoke Storms Cats Dogs Rain
Feathers Exercise Cut Grass Other: _____*

When visiting or living in other areas, are your symptoms:

Better Same Worse Unknown

Medicines that helped you?

Did not help you? _____

Hospitalizations for Chest Symptoms

Have you ever been hospitalized overnight for asthma or any other lung problems? If so, what problem and when? _____

In the last 12 months have you needed any urgent physician or emergency room care? _____ How many visits? _____

How many days of work or school were missed per year? _____

Any Reaction to Foods, Medications or Insects? Please circle:

*Peanuts Soy Tree Nuts Milk Eggs Wheat Fish Shellfish Seeds
Fruits Vegetables Spices Penicillin Aspirin Local Anesthetic
Bees Yellow Jackets Wasps Hornets Mosquitoes Ants
Other: _____*

Symptoms: Local Reaction Itchy Mouth or Lips Hives Wheezing

Explain: _____

What are your hobbies?

Do other exposures (food, medicine) aggravate your symptoms?

Do you get rashes from contact with:

*Poison Ivy Grass Latex/Rubber Mango Plastic Nickel/Metal
Adhesive Cosmetics Leather*

Describe: _____

Past History

Did you have any of the following infections:

*Sinus Ears Throat Chest Bronchitis Pneumonia Bladder
Kidneys Skin Yeast Meningitis Other (specify) _____*

Patient less than 15 Years Old:

Delivery: Normal _____ Other: _____

Neonatal Problems (example: premature birth) ? _____

Feeding Problems? _____

Immunizations - Any unusual problems? _____

What illnesses do you have or have you had?

Pneumonia _____ times	Rheumatic Fever
Emphysema	Diabetes
Tuberculosis	Heart Disease
Heart Murmur	Glaucoma
High Blood Pressure	Ulcer
Unusual Infections	Arthritis
Thyroid Disease	Liver Disease
Kidney Disease	Prostate
Cancer	
Other: _____	

Do you smoke? Y N

If yes, circle: *Cigarettes Pipe Cigars Chewing Tobacco*

How many years? _____ how many per day? _____

If you **do NOT smoke**, are you exposed to smoke? Y N

If yes, circle: *At Home At Work Both Other* _____

Family History

Circle One: *Married Single Divorced*

Are your parents alive? Age: Mother _____ Father _____

If parents died, at what age? Mother _____ Father _____

Do you have Brothers? _____ Sisters? _____

Do you have children?

Sons: _____ Daughters: _____

Are there any unusual medical problems in the family? If so, explain:

	Hay Fever	Asthma	Eczema	Hives	Insect Allergy	Drug Allergy	Sinus	Food	Other
<u>Mother</u>									
<u>Father</u>									
<u>Sisters</u>									
<u>Brothers</u>									
<u>Aunts</u>									
<u>Uncles</u>									
<u>Grandmothers</u>									
<u>Grandfathers</u>									
<u>Other</u>									

Environmental Survey

● **Where did you grow up?** _____
How long have you lived in this area? _____
 If less than 5 years, where did you live in the previous 5 years? _____

● **Residence (circle those that apply):** *Urban Suburban Rural*

House Townhouse Condominium Mobile Home Apartment Age _____

Basement Dry _____ Damp _____ Frequent Mildew _____

Heated and Cooled by (Circle those that apply):

*Forced Air Gas Electric Radiators Baseboard Hot Water
Heat Pump Central Air Conditioning Attic Fan Window Air
Conditioning
Window Fan Other: _____
Humidifier De-Humidifier Room Hepa or AirFilter*

Smokers in Home: Y N

Pets: *Cat(s) _____ Dog(s) _____ in bedroom? Y N*
Indoor Plants: *Many Few In Bedroom*
Unusual or foreign items in house? (Ex., silk) _____

● **Bedroom**

Number of beds in patient's room? _____ Waterbed? _____

Mattress: Inner-spring: *Foam Age? _____ Other _____*

Pillow: *Foam Synthetic Feather Kapok Other _____*

Blankets or Bedspread: *Woolen Synthetic Cotton Age? _____*

Rug: *Woolen Synthetic Cotton Age? _____ Other _____*

Curtains: *Shades Drapes Shutters Blinds Other _____*

Stuffed Furniture: *Stuffed Animals Water Damage*

Chemical Exposure at Work or at Home

Trees in your yard: *Oak Hickory Maple Other: _____*