The Asthma & Allergy Center

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Patient History

Date: _____ Name: _____Age: _____

Address: _____City:_____ State:_____ Zip Code: _____

Occupation: _____Primary Care Physician: _____

Referred By: _____

What are your goals for this evaluation? _____

1. Please ***CHECK (√)*** the conditions that have bothered you in the last 12 months.

CONSTITUTIONAL:
- _____Chills
- _____Dizziness
- _____Fever
- _____Poor appetite
- _____Sweats
- _____Weight gain
- _____Weight loss

EYES:
- _____Itching
- _____Redness
- _____Swelling
- _____Vision changes
  Last vision test:_____
- _____Watering

EARS:
- _____Draining
- _____Fluid behind eardrum
- _____Frequent ear infections
- _____Hearing loss
- _____Itching
- _____Popping
- _____Ringing

NOSE:
- _____Bleeding
- _____Itching
- _____Mouth breathing
- _____Polyps
- _____Runny nose
- _____Sinus infections
- _____Sneezing
- _____Stuffiness
- _____Change in smell

MOUTH/THROAT/NECK:
- _____Dental problems
  Last dental exam:_____
- _____Drainage
- _____Itching
- _____Soreness
- _____Swallowing difficulty
- _____Swelling of thyroid
- _____Throat clearing

CHEST:
- _____Bronchitis
- _____Coughing
- _____Pain/pressure/discomfort
- _____Phlegm/sputum/mucus
- _____Pneumonia
- _____Shortness of breath
- _____Tightness
- _____Wheezing

HEART:
- _____Discoloration of nails
- _____High blood pressure
- _____Irregular beats
- _____Racing heart
- _____Stroke

SKIN:
- _____Discoloration
- _____Dryness
- _____Eczema
- _____Growths
- _____Hives/welts
- _____Itching
- _____Poor wound healing
- _____Rash
- _____Swelling-lips, hands, feet
- _____Wart/Mole changes

BACK/EXTREMITIES/ NEUROLOGICAL:
- _____Decreased movement
- _____Muscle pain
- _____Numbness
- _____Seizures
- _____Swollen feet
- _____Trembling
- _____Varicose veins
- _____Weakness

NERVOUS SYSTEM:
- _____Headache
- _____Irritability
- _____Unusual fatigue

GASTROINTESTINAL:
- _____Abdominal pain
- _____Black stools
- _____Bleeding
- _____Change in bowel
- _____Change in eating habits
- _____Constipation
- _____Diarrhea
- _____Heartburn/Acid reflux
- _____Indigestion
- _____Nausea
- _____Vomiting

BREAST:
- _____Drainage
  Last mammogram: _____
- _____Nodules or masses
- _____Pain
- _____Swelling

GENITOURINARY:
- _____Blood in urine
- _____Incontinence
- _____Burning
- _____Color change
- _____Frequency of urination
- _____Kidney/Bladder infections
- _____Painful urination
- _____Prostate enlargement
- _____Start/Stop difficulty
- _____Stone

OB: # of pregnancies: _____
Children birthed: _____

GYN:
Contraception use: _____
Last Menstrual Period: _____
Last PAP/pelvic exam: _____
- _____Abnormal bleeding
- _____Discharge
- _____Spotting

PSYCHIATRIC:
- _____Behavior change
- _____Depression
- _____Anxiety
- _____Fears
- _____Emotional changes
- _____Mood swings

2. Are you having any symptoms other than those listed above? _____

_____

	Nose/Eye Symptoms	Chest Symptoms	Skin Symptoms
When did these symptoms begin?	(year) _____	_____	_____
Where did these symptoms begin?	(state) _____	_____	_____

When did you last have symptoms? _____ What time of day are they worse? _____

Underline the months in which your symptoms occur. Use ***2 lines*** to indicate months when symptoms are worse.

JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

3. Have your symptoms been severe enough to interfere with your sleep or daily routine? _____yes _____no
   In what way?_____

   Have you missed any days of work or school this year because of these medical problems? _____yes _____no
   If so, how many?_____

   Have you ever received emergency treatment for the above symptoms, allergies or asthma? _____yes _____no

   Have you ever been hospitalized for asthma or the above symptoms? _____yes _____no
   If yes, when and where?_____

   Have you ever been admitted to the intensive care unit for asthma or allergies? _____yes _____no

   Have you ever been on oral or injectable steroids for your allergy or asthma? _____yes _____no
   How many times?_____

   Have you lived in other states? _____yes _____no
   If yes, where?_____

   Have you been skin tested for allergies? _____yes _____no
   If yes, when and where?_____

   Have you received allergy shots? _____yes _____no
   If yes, for what allergens?_____

   When?_____Where?_____

   Did it help? _____yes _____no

4. What medications have been used for your symptoms?

	Nose Symptoms mcg, times/day	Helpful	No Relief	Chest Symptoms mg, times/day	Helpful	No Relief
1.	_____	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____	_____

5. Mark the following items that make your nose/eyes ***(mark "N")*** and your chest ***(mark "C")*** symptoms to start or become worse.

____Trees	_____Other animals	____Foods(which ones?)	____Bright sun
____Dead leaves	(which ones?)	_____	____Cold air
____Grasses	_____	_____	____Exercise
____Weeds	____Vacation/camping	_____	____Laughing
____Housedust	____Insect bites	____Weather changes	____Coughing
____Mildew	____Fumes/odors	____Fog	____Anger
____Farms/barn/hay	____Natural gas	____Wind	____Emotional upset
____Flowers	____Car exhaust	____Heat	____Tobacco smoke
____Animals (which ones?)	____Perfumes/Cosmetics	____Rain	____Smog
____Cat	____Insect dust/sprays	____Dampness	____Other:_____
____Dog	____Drinks	____Chilling	

6. FAMILY HISTORY OF ALLERGY: If present, ***check (√)*** the following.

	Year of Birth	*Healthy*	*Asthma*	*Hayfever*	*Hypertension*	*Eczema*	*Sinus Disease*	*Diabetes*	*Heart Disease*	*Cancer*	*Food Allergy*	*Thyroid Disease*	*Swelling Episodes*	*Recurrent Infections*	*Hives*
Father	____	____	____	____	____	____	____	____	____	____	____	____	____	____	____
Mother	____	____	____	____	____	____	____	____	____	____	____	____	____	____	____
Children	____	____	____	____	____	____	____	____	____	____	____	____	____	____	____
Siblings	____	____	____	____	____	____	____	____	____	____	____	____	____	____	____
Maternal Family Members	____	____	____	____	____	____	____	____	____	____	____	____	____	____	____
Paternal Family Members	____	____	____	____	____	____	____	____	____	____	____	____	____	____	____

Do any other illnesses seem to run in your family?

Mother's family: _____

Father's family: _____

7. ENVIRONMENTAL SURVEY:

Dwelling: Year moved into present home _____

Type of dwelling: ☐Suburban or ☐Rural or ☐Urban

Age of dwelling _____

☐ Single Family ☐ Apartment ☐ Multiple homes ☐ Assisted Living ☐ Nursing home ☐ Dorm Room

Exposure at workplace: ☐ fumes ☐ dust ☐ chemicals, which ones? _____

Please ***check (√)*** all items found in your home. ***Check twice (√√)*** if items are also found in your bedroom.

____Basement
____Forced air furnace – Gas _____
Electric _____
____Window air conditioner
____Central air conditioner
____Air cleaner
____Humidifier
____Handicrafts
____Carpet
____ Stove – Gas _____
Electric _____

____Drapes
____Feather pillows
____Stuffed furniture
____Stuffed toys
____Plastic covered mattress
____Mold/Mildew
____Potted plants
____Regular use of insect spray
____Second hand smoke exposure

____Cat
____Dog
____No indoor pets

____Farm animal (which ones)_____
_____
____Other pets – specify
_____

How long have you had this pet? _____

CROSS (X) where your symptoms are worse, ***CHECK (√)*** where they are better:

_____Indoors _____Outdoors _____At home _____At school _____At work
_____Away from home _____In air conditioning _____Same at all locations

8. Have you ever had any trouble from any of the following items: ***Check (√)*** and write what reaction was.

Medicines:	*Type of Reaction*	*Immunizations:*	*Type of Reaction*	*Contactants:*	*Type of Reaction*
_____Penicillin	_____	_____Tetanus	_____	_____Metals	_____
_____Aspirin	_____	_____Influenza	_____	_____Poison ivy/oak	_____
_____Others	_____	_____Others	_____	_____Latex	_____
				_____Others	_____

Insect stings or bites:	*Type of Reaction*	*Foods:*	*Type of Reaction*
_____Bees	_____	_____Milk	_____
_____Wasps	_____	_____Eggs	_____
_____Others	_____	_____Seafoods	_____
		_____Tang	_____
		_____Others	_____

9. Past History:

Do you smoke? Yes_____ No _____

What do you smoke?_____

How much do you smoke each day? _____For how many years?_____

Are there smokers in your home? Yes_____ No _____Does smoke bother you? Yes _____ No_____

Have you taken any illicit drugs? Yes _____ No _____ If so for how many years? _____

What type? _____ Are you still using? Yes _____ No _____

Do you have a chronic illness? (diabetes, hypertension, convulsions, etc.) Please list:

_____

_____

Immunizations:

DTaP (under age 7)	Last given? _____	Facility? _____
HEP A	Last given? _____	Facility? _____
HEP B	Last given? _____	Facility? _____
Human Papillomavirus	Last given? _____	Facility? _____
Influenza	Last given? _____	Facility? _____
MMR	Last given? _____	Facility? _____
Meningococcal	Last given? _____	Facility? _____
Pertussis	Last given? _____	Facility? _____
Pneumococcal	Last given? _____	Facility? _____
Polio	Last given? _____	Facility? _____
Prevnar	Last given? _____	Facility? _____
Tdap (11 yrs & up)	Last given? _____	Facility? _____
Varicella	Last given? _____	Facility? _____
Other:_____	Last given? _____	Facility? _____

Do you take medication daily? _____If so, please list:

Name	Dosage	Times/Day	Condition treated
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you ever had any serious illness, operation, or hospitalization? _____Please list with dates:

_____ _____

_____ _____

_____ _____

Relating to your childhood illnesses:

Check (√) the diseases that you have had:

_____Mumps _____Rubeola _____Rubella _____Urinary infections _____Bronchiolitis

_____Roseola _____Pertussis _____Croup _____Chicken pox

_____Bronchitis (& frequency _____) _____Pneumonia (& frequency _____)

If patient is an infant:

Number of weeks of pregnancy_____ Labor or birthing complications_____

Birth weight _____ Breast or formula fed_____ Number of formula changes _____

Check (√) the symptoms that apply:

____Gas ___Constipation ____Colic ___Vomiting ___Mucus in stool ___Blood in stool ___Oily stool

Any other concerns? _____

_____