The Asthma & Allergy Center

3503 Samson Way #108 • Bellevue, NE 68123-4303 PHONE (402) 592-2055 FAX (402) 592-2419 www.asthmaandallergycenter.com

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
______Fatigue
______Fever
______Sweats
______Weight gain
______Weight loss

EYES:
______Dryness
______Itching
______Redness
______Swelling
______Vision changes
______Watering

EARS:
______Fullness
______Hearing loss
______Itching
______Popping
______Ringing

NOSE:
______Bleeding
______Difficulty smelling
______Drainage down throat
______Itching
______Mouth breathing
______Runny nose
______Sinus infections
______Sneezing
______Stuffiness/congestion

MOUTH/THROAT/NECK:
______Itching
______Soreness
______Swallowing difficulty
______Throat clearing
______Voice change

CHEST:
______Coughing
______Shortness of breath
______Tightness/discomfort
______Wheezing

HEART:
______Irregular beats
______Racing heart

SKIN:
______Dryness
______Easy bruising/poor wound healing
______Hives/welts
______Itching
______Rash
______Swelling-lips, hands, feet

BACK/EXTREMITIES/ NEUROLOGICAL:
______Numbness
______Swollen feet
______Tremor
______Weakness

NERVOUS SYSTEM:
______Headache

GASTROINTESTINAL:
______Abdominal pain
______Change in eating habits
______Constipation
______Diarrhea
______Heartburn/acid reflux
______Nausea/vomiting

URINARY:
______Difficulty with starting flow
______Pain
______Urinate too frequently

GYN:
______Currently pregnant

MOOD:
______Anxiety
______Behavior change
______Depression
______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
____Dead leaves
____Grasses
____Weeds
____Housedust
____Mildew
____Farms/barn/hay
____Flowers
____Animals (which ones?)
____Cat
____Dog

_____Other animals (which ones?)
____
____Vacation/camping
____Insect bites
____Fumes/odors
____Natural gas
____Car exhaust
____Perfumes/Cosmetics
____Insect dust/sprays
____Drinks

____Foods(which ones?)
____
____
____
____Weather changes
____Fog
____Wind
____Heat
____Rain
____Dampness
____Chilling

____Bright sun
____Cold air
____Exercise
____Laughing
____Coughing
____Anger
____Emotional upset
____Tobacco smoke
____Smog
____Other:______________________

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

	Year of Birth	Healthy	Asthma	Hay-fever	Hyper-tension	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*
_____Penicillin _______________
_____Aspirin _______________
_____Others _______________

Immunizations: *Type of Reaction*
_____Tetanus _______________
_____Influenza _______________
_____Others _______________

Contactants: *Type of Reaction*
_____Metals _______________
_____Poison ivy/oak _______________
_____Latex _______________
_____Others _______________

Insect stings or bites: *Type of Reaction*
_____Bees _______________
_____Wasps _______________
_____Others _______________

Foods: *Type of Reaction*
_____Milk _______________
_____Eggs _______________
_____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? ____
____