ALLERGY & ASTHMA SPECIALISTS, P. A.

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Name: ______________________ DOB: __________ Age: ______ Date: __________
Referred by: ______________________ Occupation: ______________________
Home Phone: ______________ Work Phone: ______________ Cell Phone: ______________

Please answer the questions by drawing a circle around your answer. **FOR CLINIC USE ONLY**

What is your chief concern? How long have you had symptoms? ______________________

Nasal symptoms Sinus symptoms Asthma

Drug reactions Food reactions

Insect stings Eczema Hives Other ______________

CURRENT HOME

Is your home a: House Apartment Mobile Home Townhouse Do you live in: City Suburbs Farm
How many years have you lived in your present home? __________ Age of dwelling? __________
Circle any of the following in your present home:
Cat Dog Other animals or birds Air cleaner Humidifier Air Conditioner: ☐Window ☐Central
Heating system: Forced air Hot water/radiant Gravity Wood stove/fireplace
What type of pillow do you use? ☐Fiber ☐Feather ☐Foam
Do you have encasements? ☐Pillow ☐Bed ☐Box Springs
Have you had allergy tests in the pasts? ☐Yes ☐No Results: ______________________

Are you now receiving allergy shots? ☐Yes ☐No When were they started? ______________
Have you in the past? ☐Yes ☐No When ______________________

NASAL SYMPTOMS: Circle any symptoms of the nose which occur frequently:
Itching Sneezing Stuffiness Runny nose Yellow drainage Bleeding Loss of sense of smell

Are they worse during certain months: (circle) January February March April
May June July August September October November December
What was your age when nasal symptoms started? __________
Is sleep disturbed by nasal congestion? ☐Yes ☐No ______________________
Do you have sinusitis? ☐Yes ☐No
Have you taken an antibiotic for sinus infections? ☐Yes ☐No ______________________
Have you had x-rays or a CT scan of your sinuses? ☐Yes ☐No ______________________
Have you had surgery on your sinuses or nose? ☐Yes ☐No ______________________
If yes, date of surgery ______________
Do you have a sense of smell? ☐Yes ☐No ______________________
Have you had nasal polyps? ☐Yes ☐No ______________________
Do you have headaches more than once a week? ☐Yes ☐No ______________________
Do you have facial pain? ☐Yes ☐No ______________________

EYE SYMPTOMS: Circle any symptoms of the eye which occur frequently:
Itching Watering Redness Burning Dryness Loss of vision Eyelid swelling

EAR SYMPTOMS: Circle any symptoms of the ear which occur frequently:
Itching Pressure Pain Ringing Loss of hearing Infections

◊ **Please bring your completed form with you to your initial appointment** ◊

SYMPTOM PATTERNS: If you have symptoms of the nose, eyes, or ears, circle the time of the year they occur:

Spring | Summer | Fall | Winter | Off and on all year

If you have symptoms of the nose, eyes, and ears, circle any factors which make you feel worse:

Animals | House dust | Musty odor | Cold air | Food | Being indoors | Being outdoors | Being at work

Smoke | Temperature changes | Dampness | Raking leaves | Mowing lawn | Barns

Do any family members have hayfever? ☐Yes ☐No ______________________________

Past allergy medications: Name | Dosage | Frequency | Why stopped

____

____

____

____

Current allergy medications: Name | Dosage | Frequency | Helpful?

______________________________ ☐Yes ☐No

______________________________ ☐Yes ☐No

______________________________ ☐Yes ☐No

ASTHMA HISTORY: Circle chest symptoms you have had in the past 4 weeks:

Cough | Wheeze | Shortness of breath | Chest pain | Yellow mucus | Bloody mucus | Heartburn

Past asthma medications: Name | Dosage | Frequency | Why stopped

____

____

____

____

Current asthma medications: Name | Dosage | Frequency | Helpful?

______________________________ ☐Yes ☐No

______________________________ ☐Yes ☐No

______________________________ ☐Yes ☐No

______________________________ ☐Yes ☐No

Did you have chest symptoms as a child; if yes age started? _____ ☐Yes ☐No ______________

Was a diagnosis of asthma made in the past? ☐Yes ☐No ______________

Have you been in an emergency room for asthma? ☐Yes ☐No ______________

Have you ever been hospitalized for asthma? ☐Yes ☐No ______________

Have you ever had intensive care treatment for asthma? ☐Yes ☐No ______________

Were you ever on corticosteroid pills or shots? ☐Yes ☐No How many times? __________

Have you ever had an abnormal chest x-ray? ☐Yes ☐No ______________

Have you had pneumonia? ☐Yes ☐No ______________

Do any family members have asthma? ☐Yes ☐No ______________

Date of last chest x-ray: ______________________

DISEASE ACTIVITY:

Number of days per week you have chest symptoms: ______________

Number of nights per week asthma disturbs sleep: ______________

Number of days work/school missed in the past month: ______________

year: ______________

Circle the activities that are difficult due to asthma: Walking | Climbing stairs | Running | Sports

Do your present medicines control asthma: ☐Yes ☐No ______________

PATTERN OF ASTHMA:

Circle the season asthma attacks are most frequent: Spring | Summer | Fall | Winter | All year

Circle the time asthma attacks are most frequent: Morning | Afternoon | Evening | Nighttime

Circle the factors which make your asthma worse:

Animals | House dust | Smoke | Cold air | Foods | Exercise | Infections | Colds | Medication reactions

Are you exposed to chemicals or allergens? ☐Yes ☐No ______________

Are your chest symptoms worse at work? ☐Yes ☐No ______________

HIVES AND ANGIOEDEMA:

Have you had hives (red itchy welts)? ☐Yes ☐No ______________________________

Have you had swelling of the lips, eyelids, throat, hands or feet? ☐Yes ☐No ______________________________

Circle any factors which trigger hives or swelling?

Heat Cold Exercise Stress Pressure Foods Medicine Menses

Do any family members have hives or swelling episodes? ☐Yes ☐No ______________________________

Do you regularly use over the counter pain relievers? ☐Yes ☐No ______________________________

Have you had a recent infection? ☐Yes ☐No ______________________________

FOOD ALLERGY:

Circle symptoms which occur after eating a specific food:

Hives Itchy mouth Swollen throat Vomiting Diarrhea Asthma Nasal congestion Shock

Which foods cause this: ____

PAST MEDICAL HISTORY:

Have you ever had surgery? ☐Yes ☐No ______________________________

List: ____

Do you have any medical problems? ☐Yes ☐No ______________________________

List: ____

Have you ever been hospitalized except for a surgery? ☐Yes ☐No ______________________________

List: ____

SOCIAL HISTORY:

Marital status: married divorced widow single

Number of children? __________ Ages ____

Family members living in your home: ____

Other adult or roommates living in your home: ____

Are you around anyone who smokes in your home? ☐Yes ☐No ______________________________

SMOKING HISTORY:

Do you or did you smoke tobacco? ☐Yes ☐No Smoking cessation assistance? ☐Yes ☐No _______________

Packs per day? _______________ Number of years? __________________ When did you stop? ______________________

Do you have second hand (passive) smoke exposure? ☐Yes ☐No ____

How many alcoholic beverages do you have per week? ________________ Per day? ________________________________

DRUG ALLERGY:

Do have any drug allergies: ☐Yes ☐No ______________________________

Name: ____

Circle symptoms that occur after taking a specific drug:

Hives Rash Itching Asthma Shock

ALL CURRENT MEDICATION:

Name	**Dosage**	**Frequency**	**Date started**

Any concerns about current medications?____

____

REVIEW OF SYSTEMS:

Are you pregnant or nursing?		☐Yes ☐No ______________________
Skin:	Problems with your skin (rash, hives, changes in skin/hair, cold sores, eczema)?	☐Yes ☐No ______________________
Ears/Eyes Nose/Throat	Problems with your eyes, ears or throat?	☐Yes ☐No ______________________
	Speech or hearing problems?	☐Yes ☐No ______________________
	Headaches (cluster, stress, migraines) or seizures?	☐Yes ☐No ______________________
	Have you seen a dentist in the past year?	☐Yes ☐No ______________________
	Sinus problems (loss of smell, polyps, infection)?	☐Yes ☐No ______________________
	Mouth/throat problems (infections, hoarseness)?	☐Yes ☐No ______________________
	Problems with vision?	☐Yes ☐No ______________________
	Cataracts?	☐Yes ☐No ______________________
Respiratory:	Lung problems (bronchitis, pneumonia, TB, emphysema)?	☐Yes ☐No ______________________
Circulatory:	Heart problems (high blood pressure, palpitations, chest pain, irregular heart beat)?	☐Yes ☐No ______________________
Gastrointestinal:	Recent problems with eating, drinking?	☐Yes ☐No ______________________
	Problems with nausea, vomiting, abdominal pain, or bloody stools?	☐Yes ☐No ______________________
	Recent weight changes or change in appetite within the last 3 months?	☐Yes ☐No ______________________
	Ulcers, hernias, indigestion, cirrhosis, or hepatitis?	☐Yes ☐No ______________________
Emotional:	Do you feel nervous, angry, suicidal, depressed, lonely, sad or out of control.	☐Yes ☐No ______________________
	Do you have trouble sleeping?	☐Yes ☐No ______________________
Immune:	Cancer, blood diseases, deficiencies, anemia?	☐Yes ☐No ______________________
Genital/Urinary:	Burning, pain or frequency when urinating?	☐Yes ☐No ______________________
	Have you been treated for a sexually transmitted disease? If yes, what ______________________	☐Yes ☐No ______________________
	Have you had kidney stones, prostate infection (male), or urinary tract infection?	☐Yes ☐No ______________________
Endocrine:	Diagnosed with diabetes? When/type ______________	☐Yes ☐No ______________________
	Do you have thyroid disease?	☐Yes ☐No ______________________
Mobility:	Muscular/joint (i.e. arthritis) bone/orthopedic problems, osteoporosis/osteopenia, or difficulty with coordination?	☐Yes ☐No ______________________

TEST/IMMUNIZATIONS

Flu shot ______________ (Date)

H1N1 Vaccine ______________ (Date)

Pneumovax ______________________ (Date)

Haemophilus Influenza Type B ______________ (Date)

Tested for TB ______________________ (Date/Result)

Chicken Pox Disease____________ (Date)

Verivax for Chicken Pox ________________ (Date)

The above information is complete and factual: ____ ___________________
(Patient/Parent/Guardian signature) (Date)

The above information has been reviewed by: ____ ___________________
(Physician's signature) (Date)

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