

ALLERGY & ASTHMA SPECIALISTS, P. A.

825 Nicollet Mall, Suite 1149
Minneapolis, MN 55402
Telephone: 612-338-3333

2805 Campus Drive, Suite 415
Plymouth, MN 55441
Telephone: 763-559-3252

9825 Hospital Drive, Suite LL11
Maple Grove, MN 55369
Telephone: 763-420-3800

Harold B. Kaiser, M.D.

Philip C. Halverson, M.D.

Gary D. Berman, M.D.

Allan Stillerman, M.D.

Richard P. Bransford, M.D.

Hemalini Mehta, M.D.

Mary Anne Elder, C.N.P.

Sarah B. Wood, C.N.P.

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_ Date: \_\_\_\_\_

Referred by: \_\_\_\_\_ Occupation: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Email: \_\_\_\_\_

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 past?  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:**

<u>Name</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Date started</u>

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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