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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
Emphysema
Tuberculosis
Heart Murmur
High Blood Pressure
Unusual Infections
Thyroid Disease
Kidney Disease
Cancer
Rheumatic Fever
Diabetes
Heart Disease
Glaucoma
Ulcer
Arthritis
Liver Disease
Prostate
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 __
Mother									
Father									
Sisters									
Brothers									
Aunts									
Uncles									
Grandmothers									
Grandfathers									
Other									

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:_____