ASTHMA & ALLERGY CENTER

Patient History Form

PATIENT NAME: DATE:

1. I am here for evaluation of the following:

__Nose and eye allergy
__Recurring bronchitis
__Asthma
__Allergic swelling
__Abnormal reaction to a medication
__Insect sting allergy
__Other reason(s): _____

__Recurring sinus infections
__Recurring pneumonia
__Hives, urticaria
__Eczema
__Abnormal reaction to a food
__Contact allergy

2. Which of these symptoms do you have? (Check all that apply)

A. Head/Eyes/Ears/Nose/Throat Symptoms:

__ Nasal stuffiness
__Itchy nose
__Itchy throat/mouth
__Drainage in the back of the throat
__Frequent clearing of throat
__Headache
__Itchy eyes
__Watery eyes
__Puffy eyes
__Runny nose
__Yellow or green nasal discharge
__Throat swelling

__Nose bleeds
__Reduced sense of smell
__Sneezing
__Snoring
__Mouth breathing
__Itching inside the ears
__Reduced hearing
__Ear pain/ discharge
__Blocked ear(s)
__Ringing in the ear(s)
__Ear discharge
__Hoarseness

B. **Chest symptoms**

__Dry cough
__Coughing up phlegm from chest
__Tightness in the chest

__Wheezing
__Shortness of breath
__Chest pain

C. Skin symptoms:

__Hives
__Eczema
__Itching

__Diffuse swelling
__Other rash
__Burning

Are skin symptoms generalized? ____Yes, _____No. (Describe location below)

_____

D. Other Symptoms (Describe): _____

3. How long has the patient had these symptoms?

Head/eyes/nose/throat symptoms (months, years) _____

Chest symptoms (months, years) _____

At what age was asthma diagnosis established? _____

Skin symptoms (months, years) _____

Other symptoms (months, years) _____

4. What is the pattern of these symptoms? (Please check)

	HEAD/EYES/EARS/NOSE/THROAT	CHEST	SKIN
Year round, No seasonal variation	_____	_____	_____
Year round, Worse seasonally	_____	_____	_____
Only Seasonal	_____	_____	_____
If Seasonal, List months	_____		

5. Which of the following increases these symptoms?

__HOUSE DUST
__CATS
__DOGS
__OTHER ANIMALS_____
__MOWED GRASS
__RAKING LEAVES
__TREE POLLEN
__GRASS POLLEN
__WEED POLLEN
__HOUSEHOLD PLANTS
__OUTSIDE DUST
__CHEMICALS
__EMOTIONAL STRESS
__OTHER_____

__PERFUMES
__COSMETICS
__SOAPS
__DETERGENTS
__TOBACCO SMOKE
__HAIRSPRAY
__MOLDY SMELLS
__STRONG ODORS
__EXERTION/PLAY
__LAUGHTER
__PAINT
__CRYING
__INFECTIONS/COLDS

__WEATHER CHANGES
__COLD WEATHER
__HOT WEATHER
__DAMP WEATHER
__WINDY DAYS
__MORNINGS
__AFTERNOON
__EVENINGS
__NIGHT TIME
__ALCOHOL
__EATING
__POWDERS
__DRUGS_____

6. List all medications including eye drops and nose sprays:

_____

_____

_____

7. Any know allergic reactions to any of the following?

(I) ANTS __NO__YES, to what? _____Type of reactions_____

(II)DRUGS __NO__YES, to what? _____Type of reactions_____

(III) FOODS __NO__YES, to what? _____Type of reactions_____

(IV) INSECTS (bee/wasp/yellow jacket/hornet)

__NO__YES, to what? _____Type of reactions_____

(V) LATEX (rubber) __NO__YES, to what? _____Type of reactions_____

(VI) MOSQUITO BITE __NO__YES, Type of reactions_____

(VII) X RAY DYE __NO__YES, Type of reactions_____

(VIII) OTHERS _____ Type of reactions_____

8. Past Medical History: Mark items that are applicable to the patient:

__Attention Deficit Hyperactivity Disorder (ADHD)
__Allergy Test (__Skin test, __Blood test) When? _____
__Allergy Shots (From_____ To_____ Current? ___YES ___NO
__Anaphylaxis history
__Arthritis conditions
__Asthma
__Bowel problems, Type_____
__COPD
__Diabetes
__Eczema
__GE Reflux Disease
__Glaucoma
__Heart problems, Type_____
__High Blood Pressure
__High cholesterol
__Other endocrine problems (Thyroid disease, etc…)
__Pneumonia
__Problems with Blood, Type _____
__Problems with Bone or Joint, Type_____
__Problems with Kidney/ Urinary Tract, Type_____
__Problems with the Nervous System, Type _____
__Recurrent ear infections (Otitis media)
__Recurrent sinus infections (sinusitis)
__Ulcer, Type _____

9. List all hospitalization in the past:

	Reason for Hospitalization	***Year When Hospitalized***
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

10. Emergency Room visits? ____NO ____YES, How many times in the past year? _____

11. Please List all past surgeries: ***AGE/YEAR*** ***NAME/TYPE OF SURGERY***

_____ _____
_____ _____

12. Has the patient had a sinus X-ray or CT scan? ____ No_____Yes, When? _____

13. Has the patient had a chest X-ray? ___ _No_____ Yes, When? _____

14. Does the patient have any of the following in his/her family?

Asthma	__NO__YES	If so, who? _____
Cystic Fibrosis	__NO__YES	If so, who? _____
Eczema	__NO__YES	If so, who? _____
Frequent Colds	__NO__YES	If so, who? _____
Hay Fever	__NO__YES	If so, who? _____
Lupus	__NO__YES	If so, who? _____
Rheumatoid Arthritis	__NO__YES	If so, who? _____
Sinus problems	__NO__YES	If so, who? _____

Others

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15. <u>Environmental/Social History</u>

How old is your home? _____How long has the patient lived in this location? _____

Is the home wood/brick/trailer/apartment? _____

Any water or flood damage? ___NO___YES If yes, where? _____

Is the home carpeted? __ NO___YES If yes where? _____

What kind of bed does the patient sleep on? __Mattress __Box spring ___Quilts ___Blankets?

Is the mattress/box spring, pillow covered by a zipper plastic or vinyl cover? ___Yes ___NO

What type of pillow does the patient sleep on? __Feather ___Foam rubber ___ Polyester

Is there air conditioning? ___NO _____Central _____Room Unit

What source of heat? _____Forced Air _____Radiators _____Baseboard _____Fireplace

Is your home near a factory? ___NO ___YES

OTHER_____

16. Do you smoke? ___YES___NO Have you ever smoked? ___YES___NO

How many packs per day do you smoke? _____ How long have you smoked? _____

If you quit, when? _____

Are there any smokers in the home? ___YES___NO If yes, who? _____

17. Please circle any of the following items that pertains to the patient:

CATS (inside/ outside)	CEILING FANS	FIREPLACE
DOGS (inside/ outside)	FANS (window/ floor)	WOOD STOVE
INDOOR BIRDS	FEATHER PILLOWS	HOUSE PLANT
OTHER ANIMALS	STUFFED ANIMALS	DOWN COMFORTERS
CURTAINS/BLINDS/SHUTTERS/SHADES		MOLD/ MILDEW

18. Where does the patient work? _____

Are your symptoms worse at work? ____YES ____NO

19. What hobbies does the patient have? _____

20. Please answer the following if the patient is a child under the age of 10 years:

Birth weight_____ C-section or vaginal delivery? _____

Any pregnancy or Delivery Complications? ___YES ___NO Premature? ___YES ___NO

Bottle or Breast- fed? _____Up-To-Date Immunizations? ___YES ___NO