ALLERGY & ASTHMA SPECIALISTS, P. A.

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Name: _____ DOB: _____Age: _____Date:_____
Parent/Guardian Name: _____ Relationship: _____
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 pasts? ☐Yes ☐No When: _____
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 _____
Do you snore? ☐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

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/allergies? ☐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 When?_____
Have you been in an emergency room for asthma? ☐Yes ☐No When?_____
Have you ever been hospitalized for asthma? ☐Yes ☐No When?_____
Have you ever had intensive care treatment for asthma? ☐Yes ☐No When?_____
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 When?_____

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

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 _____

TOBACCO USE 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 _____

Do you use any "chewed" tobacco products? ☐Yes ☐No _____

Do you use "E" cigarettes? ☐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 Other _____

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? PE tubes?	☐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? Diarrhea or constipation?	☐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? Fevers? HIV?	☐Yes ☐No _____
Genital/Urinary:	Burning, pain or frequency when urinating?	☐Yes ☐No _____
	Have you been treated for a sexually transmitted infection? If yes, what _____	☐Yes ☐No When?_____
	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)

☐Zoster Vaccination (Shingles) _____ (Date)

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

The above information has been reviewed by: _____ _____
(Physician/Provider signature) (Date)

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