

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

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

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: _____

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 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>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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 or difficulty with coordination? Yes No _____

TEST/IMMUNIZATIONS

Flu shot _____ Pneumovax _____
(Date) (Date)

Haemophilus Influenza Type B _____ Tested for TB _____
(Date) (Date/Result)

Chicken Pox Disease _____ Verivax for Chicken Pox _____
(Date) (Date)

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

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

◇ Please bring your completed form with you to your initial appointment ◇