Health History

ALLERGY & ASTHMA
SPECIALISTS, P.A.

Name: ______________________________ DOB: __________ Age: _____ Date: ____________________

Parent/Guardian Name: ____________________________ Relationship: ______________________________

Referred by Provider and Clinic Name: ____________________________ Occupation: ____________________

Home Phone:______________ Work Phone: ______________ Cell Phone: ______________________________

Email: ____

Please answer the questions by drawing a circle around your answer.
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: ______________

FOR CLINIC USE ONLY
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____
____
____

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? ________________

Are 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

Symptoms of the nose which occur frequently (circle):
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 eye symptoms which occur frequently: Itching   Watering   Redness   Burning   Dryness   Loss of vision   Eyelid swelling

Ear Symptoms

Circle ear symptoms which occur frequently: Itching   Pressure   Pain   Ringing   Loss of hearing   Infections

Symptom Patterns

Circle the time of the year symptoms of the nose, eyes, or ears 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

Did you have chest symptoms as a child? ☐Yes ☐No Age started? ________________________________

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 ☐Partner 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 and Alcohol 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? ☐Yes ☐No ____

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 heartbeat)? ☐Yes ☐No ____

Gastrointestinal:

Recent problems with eating, drinking? ☐Yes ☐No ____

Problems: nausea, vomiting, abdominal pain, bloody stools, diarrhea, 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? ☐Yes ☐No When/type:____________________________

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: ________________________________

☐ **Prevnar Vaccine**
Date: ______________________________

☐ **Pneumovax**
Date: ________________________________

☐ **Tested for TB**
*Date/Results:*_________________________

☐ **Chicken Pox Disease**
Date: ______________________________

☐ **Verivax for Chicken Pox**
Date: ________________________________

☐ **Haemophilus Influenza Type B**
Date: _______________________________

☐ **Zoster Vaccination (Shingles)**
Date: _____________________________

☐ **Covid 19 Vaccine**
Date: _______________________________

The Above Information is Complete and Factual:

____ _______________________________________

Patient/Parent/Guardian signature *Date*

The above information has been reviewed by:

____ _______________________________________

Provider signature *Date*

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