Allergy & Asthma Associates, Inc. ***------ Lawrence J. Newman, MD, Steven A. Sutton, MD and John A. Eckman MD***

Patient History

Patient Name _____ Date of Birth ___/___/___ Date: _____

Married Single Divorced Separated Widow/er Child

Sex: M F Race: _____

Occupation _____ Hobbies _____

Others living in home (please list names, ages and relationship to patient):

Primary Complaint (Why are you here?) _____

_____

_____

How long have you had this/these problem(s)? _____

Medications:

Do you have **any allergies** to drugs or medications? Yes No **Are you allergic to Latex?** Yes No

If yes, please explain: _____

List any **medications and dosage (prescription and/or herbal)** you are presently taking:

What medications **have helped**? _____

What medications have **not** helped? _____

Past Medical History: Have you had any signs or symptoms of the following medical conditions, **now or in the past?**:

Y N		Y N		Y N		Y N	
allergies		high blood pressure		psychiatric problems		scarring/keloids	
asthma		frequent heartburn		seizures		infection/boils	
hay fever		liver disease		glaucoma or cataracts		reaction to local anesthetic	
chronic bronchitis		kidney disease		visual problems		reaction to general anesthetic	
gastritis		diabetes		thyroid problems		bone or joint problems	
esophagitis		heart problems		prostate problems		bleeding problems	
immune problems		rheumatoid arthritis		urinary tract problems		HIV/AIDS	
positive TB test		cancer (Type_____)		Other _____		Other _____	

Briefly comment on any of the above conditions which have been checked: _____

_____

Did you receive routine child immunizations? NO YES Are they up to date? NO YES

Have you ever had chicken pox? NO YES Chicken pox vaccine? NO YES

Infancy: A. Birth weight: _____ Did you have any health problems just after birth? YES NO

If yes, please describe: _____

B. Did you require a respirator or need oxygen as a newborn? YES NO

Diet: Until you were 6 months old, were you: breast fed bottle fed

At what age were you first fed: Milk formula _____? Soy formula _____? Baby food _____? Table Food _____?

Do you (or did you previously) strictly avoid particular foods? YES NO

If yes, which foods and why? _____

Drug and Alcohol:

Have you ever used tobacco of any kind? YES NO If YES, type of tobacco:_____
At what age did you start using tobacco? _____
Do you smoke now? YES NO How many packs per day? _____
If NO, how long ago did you quit _____
Do you drink Alcohol? YES NO Approximately how much per week?_____
Have you or do you use illicit drugs? YES NO If YES, type :_____

Prior Allergy or SinusTesting:

Have you ever had allergy testing? YES NO If YES, when?_____
Are you currently or have you ever had allergy shots? YES NO If YES, when? _____
Have you ever had nasal or sinus surgery? YES NO If YES, when? _____
If yes, please describe what type of surgery: _____
Have you ever had sinus or lung CAT Scans or X-rays? YES NO
If YES: What? _____ When? _____ Where? _____
What? _____ When? _____ Where? _____
What? _____ When? _____ Where? _____
What? _____ When? _____ Where? _____

Major Illnesses / Previous Surgery / Hospitalizations:

Year	Illness / Surgery / Hospitalization
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Family History: Who in your immediate family have had any of the following medical conditions:

allergies _____ bronchitis _____ heart problems _____ thyroid problems _____
asthma _____ high blood pressure _____ bleeding problems _____ bone or joint problems _____
hay fever _____ psychiatric problems _____ liver disease _____ visual problems _____
eczema _____ kidney disease _____ frequent heartburn _____ stomach ulcers _____
allergic dermatitis _____ diabetes _____ tuberculosis _____ seizures _____
hives _____ cystic fibrosis _____ immunologic problems _____
cancer (type) _____ Other _____
early childhood or unexplained deaths in the close family _____ please explain: _____

Briefly comment on any of the above conditions: _____

ROS: Do you currently have any of the following symptoms:

	Y N		Y N		Y N		Y N
fatigue		body swelling		anxiety		scarring/keloids	
fever		seizure		depression		frequent infections	
weight loss		joint pain		stress		diarrhea	
eye pain		joint swelling		psychiatric problems		vomiting	
chest pain		cold intolerance		lymph node enlargement		sleep problems	
heart palpitation		heat intolerance		lymph node tenderness		bleeding problems	
abdominal pain		weight gain		rashes		rashes	
difficulty voiding		weight loss		Chills		Blood in stool	
Nail changes		Hallucinations		Tinnitus		Other	

Briefly comment on any of the above conditions which have been checked: _____
_____

Allergy only

Triggers: Which of the following make your symptom worse? (check all that apply)

colds/infection	temperature changes	laughter	exercise	raking leaves
cold or damp	odors	house dust	lawn mowing	mildew
fatigue	rain or wind	smoke or smog	grass	cats/dogs
excitement	anger/tension	pregnancy	foods	other animals

Are you **B**etter or **W**orse: At home: B W In air conditioning: B W On vacation: B W
At work: B W Out of doors: B W Other: _____

Seasons: During which months are your symptoms troublesome? (check all that apply, underline if more severe)
Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec Same all year

Environment:

1. Do you have pets? YES NO If yes, what kind? _____
2. Does anyone smoke? YES NO If yes, who? _____
3. Do you have air conditioning? NO YES
4. Are there water damaged areas or mold (mildew) in your home? YES NO
5. Are you exposed to any unusual substances (chemicals, plastics, etc.) at work, school, home, or in a hobby? YES NO
   If yes, please explain: _____
6. What type of pillows do you have? Feather Foam Synthetic Other: _____
7. What type of heat do you have? Forced Air Gravity Gas Electric Other: _____
8. How old is your home? _____

Lung:

1. Have you ever had a wheezing attack? YES NO If so: How frequently? _____
   Last hospitalization for wheezing __ / __ / __ Last emergency room visit for wheezing __ / __ / __
2. Have you had pneumonia? YES NO
3. Have you had bronchitis? YES NO If so, how often?_____
4. Do you cough frequently? YES NO If yes, is it daily? nightly? after meals?
5. Do you cough or wheeze during (or after) exercise? YES NO
6. Do you cough up blood? YES NO
7. Do you ever have heartburn? YES NO
8. Do you have fatty, greasy stools? YES NO
9. Unwanted weight gain or loss? YES NO
   If yes, explain _____
10. Do your chest problems discourage or prevent normal physical activity? YES NO
11. Have you missed work (school) or sleep because of your chest problems? YES NO
    If yes, how many days per month? _____ Per year? _____
12. At what age did your chest problems begin? _____ Are they getting: better worse staying the same?

Nose: A. Please select the symptoms you have on a frequent basis:

nasal congestion	runny nose	headaches	itchy nose
trouble hearing	nose rubbing	ear infections	itchy ears/eyes
trouble smelling	nosebleeds	head colds	sneezing
mouth breathing	post nasal drip	itchy throat	sniffing

B. Do you tire easily when your nose is congested? YES NO
C. Have you ever had your tonsils/adenoids removed? YES NO Have you ever had tubes in your ears? YES NO
D. Do you have any problem tasting food? YES NO Is your sense of smell impaired? YES NO
E. Have you ever had nasal trauma or a broken nose? YES NO Head trauma? YES NO
F. Have you missed work or school because of your nose problems? YES NO? If yes, how frequently? _____.
G. Have you missed sleep because of your nose problems? YES NO? If yes, how frequently? _____
H. How many ear infections have you had in the past 6 months? _____ 2 years? _____
I. How many sinus infections have you had in the past 6 months? _____ 2 years _____
J. At what age did your nose problems begin? _____ Are they getting: better worse staying the same?

Skin: A. Do you have a recurrent or frequent rash? YES NO If yes, does it itch? YES NO

B. Did you have eczema (allergic dermatitis) as a baby? YES NO

C. Have you ever had hives? YES NO If yes, what caused them? _____

D. Have you ever had swelling of your lips, hands, or feet? YES NO If yes, what caused them? _____

E. At what age did your skin problems begin? _____ Are they getting: better worse staying the same?

Food/Drug/Insect: Have you ever had an unusual or allergic reactions to any medicines? YES NO

Have you ever had an unusual or allergic reaction to insect stings? YES NO

Have you ever had an unusual or allergic reaction to aspirin? YES NO

Have you ever had an unusual or allergic reaction to alcohol? YES NO

Have you ever had an unusual or allergic reaction to sulfites/preservatives? YES NO

Have you ever had an unusual or allergic reaction to any foods? YES NO

If yes, please describe: _____

_____

_____

Physician Signature: _____ Date: _____

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