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Name_____ Date_____

Referring Physician/Address/Phone Number:_____
_____
Main Reason for Appointment Today: _____
_____

| **Do you have:** | Yes | No |
|---|---|---|
| Nasal Congestion: | _____ | _____ |
| Sneezing: | _____ | _____ |
| Runny Nose: | _____ | _____ |
| Drainage at the Back of Your Throat: | _____ | _____ |
| Frequent Yellow or Green Drainage: | _____ | _____ |
| Frequent Sinus Infections: | _____ | _____ |
| Itchy Eyes: | _____ | _____ |
| Watery Eyes: | _____ | _____ |
| Shortness of Breath: | _____ | _____ |
| Wheezing: | _____ | _____ |
| Coughing: | _____ | _____ |
| Diagnosis of Asthma: | _____ | _____ |
| Past Hospitalization for Asthma: | _____ | _____ |
| Possible Reactions to Foods: | _____ | _____ |
| Possible Reactions to Medications | _____ | _____ |
| Rashes: | _____ | _____ |
| Eczema: | _____ | _____ |
| Bee/Wasp Sting Reactions: | _____ | _____ |
| Frequent Bronchitis/Pneumonia: | _____ | _____ |
| Reactions to Latex | _____ | _____ |

**Any other symptoms of any kind?**

**_____**
**_____**

**Symptoms occur most often** :

_____Spring _____Summer _____Fall _____Winter _____Year Round

**Symptoms worse with:**

| | | | |
|---|---|---|---|
| ____Cold Air | ____Cigarette Smoke | ____Chemicals | _____Aerosol Sprays |
| ____Cosmetics | ____Plants (Poison Ivy) | ____Dusting/Cleaning | _____Colds/Flu |
| ____Pets | ____Fresh Cut Grass | ____Raking Leaves | _____Weather Changes |
| ____Exercise | ____Sunscreen | | |

Name:_____ Date:_____

Are you currently pregnant? _____No _____Yes _____Not applicable

Do you have any other medical conditions? (high blood pressure, diabetes, etc)_____

_____

**Current Medications:**

| Name | Dose | How often taking |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**Allergies to any medications: ____ No _____Yes**

| Name of medication | Reaction you had to the medication |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Prior surgeries**:

| When was surgery | Type of surgery |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Prior hospitalizations**:

| | |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**Family History of Medical Conditions (Asthma, Allergies, Food Allergies, High Blood Pressure, Etc)**

| Relative | Conditions they have |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Name:_____ Date:_____

**Social History/Environmental History**

Home Type: _____Apt
_____Condo
_____House
_____Private

Pets: _____None
_____Cats _____ How many
_____Dogs _____ How many
_____Other _____What type of pet

Carpet or Rugs in the home: _____None
_____Yes _____Bedroom _____Living Room _____Other

Mold in Home: _____None
_____Yes ____Bathroom _____Bedroom ____Other

Feather Pillow/Down Comforter: ____None
____Yes _____Down Comforter _____Feather Pillow

Special Allergy covers on bed: ____None
____Yes ___On Mattress ____On Pillows

Do you smoke? ____No
____Yes _____How much _____How long have you been smoking
____Quit _____How much _____How long _____ Stopped when
Drink alcohol? ____No ____Yes _____ Drinks per week

Use any recreational drugs: ____No ____Yes

Heating and AC type: _____Window
_____Radiator
_____Central
_____Wall unit
_____ Other

Cockroaches in the home: ____None ____Yes

Occupation: _____

Do you exercise? ____No ____Yes
Difficulty exercising? _____No _____Yes _____What symptoms do you have

Your Height _____ Your Weight _____

Signature:_____ Date:_____

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## Review of Systems

**Please check if you have any of the following, or check the "none of the above symptoms"**

**General**
___ Chills
___ Fever
____Night Sweats
___ Severe Fatigue

**Eyes**
__Itchy Eyes
__Watery Eyes
__Burning
__Eye Pain
__Double Vision
__Wear Glasses/Contacts

**Ear/Nose/Throat**
__Bad Breath
__Decreased Taste or Smell
__Ringing in Ears
__Ear Pain
__Decreased Hearing
__Frequent Throat Clearing
__Hoarseness
__Sore Throat
__Stuffy
__Nose Bleeds
__Postnasal Drip
__Runny Nose
__Sinus Pressure
__Sneezing
__Snoring

**Respiratory**
__Chest Tightness
__Cough
__Shortness of Breath
__Wheezing
__Trouble Breathing

**Cardiovascular**
__Chest Pain
__Leg Swelling
__Palpitations

**Gastrointestinal**
__ Abdominal Pain
__ Bad Taste
__ Bloating
__ Vomiting
__Diarrhea
__ Frequent Belching
__ Nausea

**Neurologic/CNS**
__Lightheaded
__Fainting
__Headache
__Numbness/Tingling
__Sleep Disturbance
__Snoring
__Insomnia

**Musculoskeletal**
__Joint Pain
__Muscle Pain
__Weakness
__Pain

**GU/Gynecologic**
__Frequent Urination
__Painful Urination
__Irregular Periods
__Painful Periods

**Skin**
__Rash
__Dry Skin
__Hives

**Psychological**
__Anxiety
__Depression

**Endocrine**
__Large Weight Gain
__Large Weight Loss
__Cold Intolerance
__Heat Intolerance

**____I HAVE NONE OF THE ABOVE SYMPTOMS**

Signature:_____ Date:_____