

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: _____

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: _____