Name ____ Age ________ Date _____________

Reason for appointment____

____

Current Medications

____

____

____

Drug allergies: Name ___________ Reaction ____
Name ___________ Reaction ____
Name ___________ Reaction ____

Medical History (List all medical conditions)

____

____

Past Surgeries: ____

____

Hospitalizations: ____

____

Family history: Check all that applies

Age	Father:	Mother:	Sisters:	Brothers:	Children:
Do they have?					
Hay Fever					
Asthma					
Hives					
Eczema					
Sinusitis					

List illnesses that run in family: ____

____

Do you smoke tobacco? Yes ___ No _____ Chew ____ Dip _____

If yes, number of years _______ How much per day ____

How long after awakening before you smoke first cigarette? ____________________________________

Are you interested in quitting? Yes ____ No ____

Do you smoke anything else: Yes ____ No ____

Environmental History:

What type of flooring do you have: Wood ______ Carpet ______ Tile _____ Other: _______

What type of heating do you have: Gas ____ Electric ____ other __________

Age of current home: _____

Air Conditioning: Central _____ Window ____ None _____

Are pets present in home? Dog ___ Cat ___ Bird ___ other: ___________________________________

Is your pillow: Foam ___ Cotton ___ Feather ___ Temperpedic ___ Other ____________________

Does your home have: Humidifier ___ mold/mildew present ___ house plants ___ Aquarium ___

Dehumidifier ___ basement ___

Review of Systems:

General

Change of appetite Yes ____ No ____

Chills Yes ____ No ____

Fatigue: Yes ____ No ____

Headache: Yes ____ No ____

Weight Change: Gain ____ Loss____ None____

Allergy

Watery Eyes Yes ___ No ___

Congestion: Yes ____ No ____

Hives: Yes ____ No ____

Itching: Yes ____ No ____

Rash: Yes ____ No ____

Sneezing: Yes ____ No ____

ENT

Decrease hearing Yes ___ No ___

Sore throat Yes ___ No ___

Swollen glands Yes ___ No ___

Ear pressure Yes ___ No ___

Dry mouth Yes ___ No ___

Nosebleeds Yes ___ No ___

Ear pain Yes ___ No ___

Sinus pain Yes ___ No ___

Respiratory

Chest pain Yes ___ No ___

Cough Yes ___ No ___

Hemoptysis Yes ___ No ___

Wheezing Yes ___ No ___

Sputum production Yes ___ No ___

Skin

Itching Yes ___ No ___
Rash Yes ___ No ___
Dry Skin Yes ___ No ___
Eczema Yes ___ No ___
Hives Yes ___ No ___

Ophthalmologic

Blurred vision Yes ___ No ___
Discharge Yes ___ No ___
Dry Eyes Yes ___ No ___
Itching Redness Yes ___ No ___
Floaters Yes ___ No ___

Gastrointestinal

Abdominal pain Yes ___ No ___
Diarrhea Yes ___ No ___
Nausea Yes ___ No ___
Vomiting Yes ___ No ___

CHECK OTHER SYMPTOMS:

Nasal stuffiness ___
Loss of taste/smell ___
Eczema ____
Swelling __
Ear Stuffiness ___
Ear infections _____
Post nasal drip ____
Sinus infections __
Fever ___
Night cough ____
Wheeze with exercise __
Wheeze with cold air __

WHAT MAKES SYMPTOMS WORSE:

Dry weather ___
Wet weather ___
Cold Weather ___
Change in weather ___
Being outside ____
Being in basement ___
Tobacco smoke ___
Perfumes ___
Eating ___
Alcohol ___
Exposure to Dogs __Cats ___

Do you drink alcohol? Yes__ No __ How much? ___________________

Are your symptoms worse in the: Winter ___ Spring ___ Summer ___ Fall ___ Year round ____

Food allergies: Name ___________ Reaction ____
Name __________ Reaction ____
Name __________ Reaction ____

Insect allergies: Name __________ Reaction ____
Name __________ Reaction ____
Name __________ Reaction ____

CONTACT ALLERGIES:

Poison Ivy/oak ____ Shampoo ___ Perfume ___ Latex ___

Soap ___ Detergent ___ Other _________________________

Do you carry an Epipen Yes ___ No ____

Have you ever seen an allergist before? ______________
When? _______________ Skin tested? Yes ___ No ___ Allergy injections Yes ___ No ____
Did allergy shots help? Yes ___ No ____ Stop date ______________

ANSWER THE FOLLOWING ONLY IF YOU HAVE EXPERIENCED HIVES OR ANGIOEDEMA (SWELLING)

First occurrence ____________ Present now? _____

Worse or becoming more frequent Yes ___ No ___

What is the suspected cause? ____

How long do episodes last? ____

Location of hives/swelling ____

Check if any of these make hives or swelling worse: Exercise __ Heat ___ Hot baths ___

Sweating ___ Emotional upset ___

Do you have: Heat/cold intolerance? ___________ Change in skin or hair ______
Thyroid problems _____

Are symptoms worse during menstrual period Yes ___ No ___ NA ___

Check if any of these symptoms present: Fever ___ Weight loss ___ Joint stiffness ____
Muscle tenderness ___ Aching or swelling ___ Enlarged lymph nodes ___

Does any of the following cause your skin to itch or burn? Cold ____ Heat ___ Water ___
Sunlight ___ Vibration ____ Pressure ____