Allergy & Asthma Medical Group of the Bay Area, Inc
New Patients

Name:_________________________________ DOB:__________ Visit Date:________
Other family member seen by this practice:_____________________________________
____
Referred to our office by:____________________________ Insurance:_______________
Pharmacy: ____
Mail Order Pharmacy: ____

Main Reason for Visit:____

When did Symptom start? Onset:_____days/mos/yrs Duration:____days/mos/yrs

Severity: ☐ mild ☐ moderate ☐ severe ☐ incapacitating

Frequency: ☐ intermittent ☐ persistent ☐ occasional

Status (Currently): ☐ resolved ☐ improved ☐ no change ☐ worsened

Aggravated by: ☐ Nothing

- ☐ airborne chemicals
- ☐ animals
- ☐ cat
- ☐ change in weather
- ☐ cold air
- ☐ dog
- ☐ dust/dust mites
- ☐ exercise
- ☐ foods
- ☐ molds
- ☐ nasal decongestant spray
- ☐ pollen
- ☐ respiratory infections
- ☐ smoke
- ☐ stress
- ☐ strong odors / perfume
- ☐ winter
- ☐ spring
- ☐ summer
- ☐ fall

Timing:

- ☐ morning
- ☐ evening
- ☐ bedtime
- ☐ lying down
- ☐ on wakening
- ☐ night worsening
- ☐ other:_____________________
- ☐ at home
- ☐ at work/school
- ☐ inside
- ☐ outside
- ☐ with URI's
- ☐ with weather changes
- ☐ seasonally
- ☐ winter
- ☐ spring
- ☐ summer
- ☐ fall
- ☐ year round

Other Medical History

☐Allergies (nose/eyes)
☐Anemia/low red cells
☐Angina (heart-related chest pain)
☐Anxiety/depression
☐Arthritis
☐Asthma
☐Atrial fibrillation
☐Autoimmune disease___________
☐Benign prostate enlargement
☐Blood clots
☐Cancer _____________
☐Stroke
☐COPD/emphysema
☐Heart disease
☐Crohn's Disease
☐Diabetes
☐Gallbladder disease
☐Heartburn
☐Hepatitis A
☐Hepatitis B
☐Hepatitis C
☐High cholesterol
☐High blood pressure
☐Irritable bowel
☐Liver disease
☐Migraine headaches
☐Heart attack
☐Osteoporosis
☐Peptic ulcer disease/stomach ulcers
☐Pneumonia
☐Kidney disease______________
☐Multiple Sclerosis
☐Seizure disorder
☐Thyroid disease______________
☐Tuberculosis
☐ Other____

Past Surgical History

☐Adenoidectomy
☐Angioplasty
☐Angioplasty +stent
☐Appendectomy
☐Back surgery
☐Coronary bypass
☐Carpal tunnel
☐Cataract
☐Gall bladder
☐Cholecystectomy
☐Colectomy
☐Colostomy
☐Hernia repair
☐Knee replacement
☐LASIK
☐Liver biopsy
☐Ear tubes
☐Fracture repair
☐Pacemaker
☐Sinus surgery
☐Small bowel resection
☐Thyroidectomy
☐Tonsillectomy
☐Breast augmentation
☐Tubal ligation
☐Breast biopsy
☐C-section
☐D and C (Uterus)
☐Hysterectomy
☐Mastectomy
☐Fibroid removal
☐Breast reduction
☐Hysterectomy and ovary removal
☐Vaginal hysterectomy
☐Prostate biop.
☐Prostate
☐Vasectomy
☐other____

Family History

❒Check if Adopted

	MOTHER	FATHER	SISTER	BROTHER	CHILDREN	OTHER RELATIVE
Allergies—nasal or eye						
Asthma						
COPD, emphysema or cystic fibrosis						
Eczema						
Food allergies						
Recurrent sinus or lung infection						
Smoker						
Other significant illnesses						

Social History

Tobacco use ☐ Current ☐ Former ☐ Never ☐ Unknown type ____________ packs per day______
Years smoked ________ Ever tried to quit ☐ yes ☐no yr quit_______ Longest Tobacco Free ____________
Relapse Reason______________________________ Passive smoke exposure ☐ yes ☐ no
☐ Current every day smoker ☐ Smoker, current status unknown ☐ Former smoker
☐ Current some day smoker ☐ Never smoker ☐ Unknown, if ever smoked
Alcohol use ☐ yes ☐ no ☐ former type ___________________ frequency______ amount ________ last drink_______________
Caffeine user ☐ yes ☐ no type(s)______________________ ______________________ amount daily _____________
Drug Use ☐ yes ☐ no ☐ former type(s)____

Current Allergy/Asthma Medications

(drug name)	(strength)	(number of times per day)

Current Medications for Other Conditions

(drug name)	(strength)	(number of times per day)

Homeopathic/Herbal/Complimentary/Alternative treatments:____

Drug Allergies____

Other Symptom Review (circle those that you are experiencing):

General:
- Chills
- Fatigue
- Fever
- Weakness
- Night Sweats
- Weight gain
- Weight loss

Respiratory:
- Rapid breathing
- Chronic Cough
- Cough
- Frequent URI
- Coughing up blood
- Known TB exposure
- Sharp, painful breathing
- Shortness of breath
- Coughing up sputum
- Tight throat
- Extra muscles to breathe
- Wheezing
- Other: __________

Stomach/Intestines:
- Abdominal pain
- Bloating
- Blood in stools
- Change in stools
- Constipation
- Diarrhea
- Heartburn
- Loss of appetite
- Nausea
- Reflux
- Vomiting
- Other: __________

Neurological:
- Inappropriate interaction
- Dizziness
- Extremity numbness
- Extremity weakness
- Walking Disturbances
- Headache
- Incoordination
- Lightheadedness
- Memory loss
- Seizures
- Tremors
- Sense of room spinning
- Other: __________

Musculoskeletal:
- Back Pain
- Bone/joint symptoms
- Joint pain
- Joint swelling
- Muscle weakness
- Neck pain
- Other: __________

Heat/Eyes/Ears/Throat:
- Trouble swallowing
- Ear drainage
- Ear infection
- Ear pain
- Eye discharge
- Eye pain
- Eye redness
- Hearing loss
- Hoarseness
- Itchy eyes
- Nasal congestion
- Nasal drainage
- Post nasal drip
- Runny nose
- Sinus pressure
- Sneezing
- Sore throat
- Tearing
- Visual changes
- Other:__________

Cardiovascular:
- Chest pain
- Pain in legs with walking
- Areas of body turn blue/purple
- Swelling
- Trouble breathing at night
- Shortness of breath when lying down
- Irregular heartbeat
- Fainting
- Other: __________

Metabolic/Endocrine:
- Abnormal sleep pattern
- Cold intolerance
- Goiter
- Heat intolerance
- Increased activity
- Excessive thirst
- Excessive hunger
- Other: __________

Psychiatric:
- Anxiety
- Depression
- Insomnia
- Other: __________

Hematologic/Lymphatic:
- Easy bleeding
- Easy bruising
- Swollen glands
- Other: __________

Skin:
- Brittle hair
- Brittle nails
- Frequent skin infections
- Hair loss
- Excessive hair growth
- Hives
- Itchiness
- Mole changes
- Rash present
- Skin lesion
- Other: __________

Immunologic:
- Bee sting allergies
- Contact allergy
- Environmental allergies
- Food allergies
- Seasonal allergies
- Other:__________

Home/Work Environment

Area of residence during early life ❒Bay Area ❒Other____
Hobbies____
Symptoms increased at work ❒Yes ❒No Explain if yes____________________________

Current Residence 1

Type________________ Age of building_________
How long have you lived at your current residence?_______
❒Yard ❒Ranch ❒Farm ❒Near open fields
Smokers in home ❒Yes ❒No
❒Self ❒Spouse ❒Father ❒Mother ❒other____________
Type of Bed: ❒Boxspring ❒Waterbed ❒Foam ❒Crib ❒Allergy Covered
Down Bedding? ❒Pillow ❒Comforter ❒Featherbed ❒Blanket
Bedroom: ❒Carpeted ❒Blinds ❒House Plants
❒Books ❒Drapes ❒Stuffed animals
Type of Floors: ❒Carpet ❒Hardwood ❒Tile ❒Large Area Rug
Vacuum ❒Regular ❒HEPA ❒Central
Any damp, moldy areas of house? ❒Yes ❒No _______________
Infestation with: ❒Mice ❒Rats ❒Cockroaches ❒Other________
Animals in the home ❒Yes ❒No
Type(s) ____________________ Numbers:_______
Kept Inside ❒Yes ❒No
Kept in Bedroom ❒Yes ❒No

Current Residence 2

Type________________ Age of building_________
How long have you lived at your current residence?______________
❒Yard ❒Ranch ❒Farm ❒Near open fields
Smokers in home ❒Yes ❒No
❒Self ❒Spouse ❒Father ❒Mother ❒other_____________
Type of Bed: ❒Boxspring ❒Waterbed ❒Foam ❒Crib ❒Allergy Covered
Down Bedding? ❒Pillow ❒Comforter ❒Featherbed ❒Blanket
Bedroom: ❒Carpeted ❒Blinds ❒House Plants
❒Books ❒Drapes ❒Stuffed animals
Type of Floors: ❒Carpet ❒Hardwood ❒Tile ❒Large Area Rug
Vacuum ❒Regular ❒HEPA ❒Central
Any damp, moldy areas of house? ❒Yes ❒No _________________
Infestation with: ❒Mice ❒Rats ❒Cockroaches ❒Other__________
Animals in the home ❒Yes ❒No
Type(s) ____________________ Numbers:_______
Kept Inside ❒Yes ❒No
Kept in Bedroom ❒Yes ❒No

Occupation: ____

If you have a diagnosis of Asthma, Please complete the following questionnaire:

If you have asthma, ages 12-Adult, please fill out the Asthma Control Test information below:

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?
   ❒ All of the time ❒Most of the time ❒Some of the time ❒A little of the time ❒None of the time
2. During the past **4 weeks**, how often have you had shortness of breath?
   ❒More than once day ❒Once a day ❒3 to 6 times a week ❒Once or twice a week ❒Not at all
3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?
   ❒4 or more nights a week ❒2or 3 nights a week ❒Once a week ❒Once or twice ❒Not at all
4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?
   ❒3 or more times per day ❒1 or 2 times per day ❒2 or 3 times per week ❒Once a week or less ❒Not at all
5. How would you rate your **asthma** control during the past **4 weeks**?
   ❒Not controlled at all ❒Poorly controlled ❒Somewhat controlled ❒Well controlled ❒Completely controlled

If you have asthma, ages 4-11, please fill out the Asthma Control Test information below:

1. How is your Asthma today?
   ❒Very Bad ❒Bad ❒Good ❒Very Good
2. How much of a problem is your asthma when you run, exercise or play sports?
   ❒It's a Big Problem, Can't do what I want ❒It's a Problem, I don't like it ❒It's a Little Problem but it's ok ❒It's not a Problem
3. Do you cough because of your asthma?
   ❒Yes, All of the time ❒Yes, Most of the time ❒Yes, Some of the time ❒No, None of the time
4. Do you wake up during the night because of your asthma?
   ❒Yes, All of the time ❒Yes, Most of the time ❒Yes, Some of the time ❒No, None of the time
5. During the last 4 weeks, how many days did your child have daytime asthma symptoms?
   ❒Not at all ❒1-3 days ❒4-10 days ❒11-18 days ❒19-24 days ❒Everyday
6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?
   ❒Not at all ❒1-3 days ❒4-10 days ❒11-18 days ❒19-24 days ❒Everyday
7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?
   ❒Not at all ❒1-3 days ❒4-10 days ❒11-18 days ❒19-24 days ❒Everyday

For Office Use Only:

Form reviewed with: ❒Patient ❒Father ❒Mother ❒Other____, M.D.