Name:_____ DOB:_____ Visit date:_____
Other family member seen by this practice:_____
Referred to our office by:_____
Pharmacy:_____ Mail-order Pharmacy:_____
Main Reason for Visit 1)_____Main Symptom:_____
2)_____Onset:_____

Please complete if applicable:

☐ **ENVIRONMENTAL ALLERGIES**
Symptoms: ☐Congestion ☐Sneezing ☐Runny nose
☐Itching ☐Eye symptoms ☐ Ear symptoms
Aggravated by: ☐Dust ☐Mold ☐Cat/dog ☐Pollen
☐Exercise ☐ Smoke/perfume ☐Eating ☐ Cold air
Timing: ☐AM ☐PM ☐Fall ☐Winter ☐Spring ☐Summer
☐Indoors ☐Outdoors ☐Lying down
MEDICATIONS TRIED
_____
_____
☐ Interested in allergy desensitization ("allergy shots")?

☐ **ASTHMA** ☐ **CHRONIC COUGH**
Onset: ☐ Childhood ☐ Adulthood
Symptoms: ☐Cough ☐Wheeze ☐Sputum ☐Short of breath
Frequency:_____ Aggravated by:_____
☐ Hospitalized ☐ ER Visit(s)
☐ Oral steroids (Prednisone) -Last oral steroids:_____
☐ Reflux ☐ Sleep apnea ☐ Nasal polyps
☐ Sinusitis ☐ Aspirin sensitivity
Please complete breathing questionnaire (last page)
MEDICATIONS TRIED
_____
_____

☐ **FOOD, DRUG, OR STING REACTIONS**
Item(s): _____
Reaction: ☐ Rash ☐ Diarrhea ☐ Cough/wheeze
☐Itching ☐ Short of breath ☐ Throat tightness
☐Vomiting ☐ Swelling ☐ Other _____
Did you use Epinephrine? ☐ Yes ☐ No
Timing: ☐Immediate ☐Over 1 hour later ☐Unsure
Current avoidances:_____
_____
Do you have an Epinephrine device? ☐ Yes ☐ No
☐ Interested in oral immunotherapy? (for food allergy)

☐ **HIVES** ☐ **LIP/TONGUE SWELLING**
☐ **RASHES** ☐ **ECZEMA**
Onset:_____ Duration:_____
Triggers/exposures:_____
☐ MEDICATIONS TRIED
_____
_____
☐ Any previous reactions/rashes?
_____

Previous allergy evaluation: ☐Testing ☐Shots/immunotherapy ☐Full PFT ☐Sinus CT
Other allergic issues:_____
History of infections:_____

Other Medical History

☐Anxiety	☐Crohn's Disease	☐High blood pressure	☐Osteoporosis
☐Atrial fibrillation	☐Depression	☐Irritable bowel	☐Pneumonia
☐Autoimmune disease_____	☐Diabetes	☐Kidney disease	☐Stroke
☐Blood clots	☐GERD/reflux	☐Liver disease	☐Thyroid disease_____
☐COPD/emphysema	☐Heart disease	☐Migraine headache	☐Tuberculosis
☐Cancer_____	☐Other:_____		

Past Surgical History

☐Adenoidectomy ☐Ear tubes ☐ Sinus surgery ☐Tonsillectomy ☐Angioplasty ☐ Pace maker
☐Coronary bypass ☐Other_____

For children under 2

Birth weight_____Complications_____Breastfeeding_____Formula type_____

☐Born before 37 weeks (premature)

Family History ☐Check if Adopted

	MOTHER	FATHER	SISTER	BROTHER	CHILDREN	OTHER RELATIVE
Allergies – nasal or eye						
Asthma						
Angioedema/recurrent swelling						
Eczema						
Food allergies						
Recurrent sinus or lung infection						
Other significant illnesses						

Social History

Tobacco use: ☐Current ☐Smokeless tobacco ☐Former ☐Never. Packs per day_____ ☐Second hand exposure
Years smoked _____ Ever tried to quit ☐yes ☐no year quit _____ Longest Tobacco Free _____
Alcohol use ☐yes ☐no ☐former
Recreational drug use ☐yes ☐no ☐former type(s)_____

Current Allergy/Asthma Medications(including over the counter)

_____ | _____ | _____ | _____
_____ | _____ | _____ | _____

Current Medications for Other Conditions

_____ | _____ | _____ | _____
_____ | _____ | _____ | _____

Drug Allergies:_____

Other Symptom Review (mark those that you are currently experiencing):

General	☐Chills ☐Fatigue ☐Fever ☐Weakness ☐Night sweats ☐Weight gain ☐Weight loss
Respiratory	☐Rapid breathing ☐Cough ☐Coughing up blood ☐Known TB exposure ☐Sharp, painful breathing ☐Short of breath ☐Coughing up sputum ☐Tight throat ☐Extra muscles to breathe ☐Wheezing
Skin	☐Frequent skin infections ☐Hives ☐Itchiness ☐Mole changes ☐Rash present ☐Skin lesion
Stomach/intestines	☐Abdominal pain ☐Bloating ☐Blood in stools ☐Change in stools ☐Constipation ☐Diarrhea ☐Heartburn/reflux ☐Nausea ☐Vomiting
Neurological	☐Dizziness ☐Extremity numbness/weakness ☐Headache ☐Lightheadedness ☐Memory loss ☐Seizures
Musculoskeletal	☐Back pain ☐Bone/joint symptoms ☐Joint pain ☐Joint swelling ☐Muscle weakness ☐Neck pain
Ears/eyes nose/throat	☐Ear drainage ☐Ear pain ☐Hearing loss ☐Itchy eyes ☐Eye discharge ☐Eye pain ☐Eye redness ☐Hoarseness ☐Nasal congestion ☐Post nasal drip ☐Runny nose ☐Sinus pressure ☐Sneezing ☐Sore throat ☐Trouble swallowing
Cardiovascular	☐Chest pain ☐Leg swelling ☐Murmur ☐Shortness of breath lying flat ☐Irregular heartbeat ☐Fainting
Metabolic/endocrine	☐Cold intolerance ☐Heat intolerance ☐Excessive thirst ☐Excessive hunger
Psychiatric	☐Anxiety ☐Depression ☐Insomnia ☐Stress
Hematologic/lymphatic	☐Easy bleeding ☐Easy bruising ☐Swollen glands ☐Anemia

Home/Work Environment

Area lived during early life ☐ Bay Area ☐ Other_____Hobbies_____

Residence

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:_____

Symptoms increased at work? ☐Yes ☐No Explain if yes_____

If you have asthma or breathing problems, please complete:

Ages 12 and older, during the past 4 weeks:

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

Ages 4-11:

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, I can't do what I want □ It's a problem, I don't like it
   □ It's a little problem, but it's okay □ 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

During the past 4 weeks:

5. 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. 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. 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

Urticaria (hives) Control Test:

1. How much have you suffered from the physical symptoms of the urticaria (itch, hives, welts and/or swelling) in the last four weeks?
   □ Very much □ Much □ Somewhat □ A little □ Not at all
2. How much was your quality of life affected by the urticaria in the last 4 weeks?
   □ Very much □ Much □ Somewhat □ A little □ Not at all
3. How often was the treatment for your urticaria in the last 4 weeks not enough to control your urticaria symptoms?
   □ Very much □ Much □ Somewhat □ Seldom □ Not at all
4. Overall, how well have your urticaria symptoms been under control in the last 4 weeks?
   □ Not at all □ A little □ Somewhat □ Well □ Very Well