

Name: _____ DOB: _____ Visit date: _____

Other family member seen by this practice: _____

Referred to our office by: _____ PCP: _____

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

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Atrial fibrillation | <input type="checkbox"/> Depression | <input type="checkbox"/> Irritable bowel | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Autoimmune disease _____ | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> GERD/reflux | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Thyroid disease _____ |
| <input type="checkbox"/> COPD/emphysema | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Migraine headache | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> 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	<input type="checkbox"/> Chills <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Weakness <input type="checkbox"/> Night sweats <input type="checkbox"/> Weight gain <input type="checkbox"/> Weight loss
Respiratory	<input type="checkbox"/> Rapid breathing <input type="checkbox"/> Cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Known TB exposure <input type="checkbox"/> Sharp, painful breathing <input type="checkbox"/> Short of breath <input type="checkbox"/> Coughing up sputum <input type="checkbox"/> Tight throat <input type="checkbox"/> Extra muscles to breathe <input type="checkbox"/> Wheezing
Skin	<input type="checkbox"/> Frequent skin infections <input type="checkbox"/> Hives <input type="checkbox"/> Itchiness <input type="checkbox"/> Mole changes <input type="checkbox"/> Rash present <input type="checkbox"/> Skin lesion
Stomach/intestines	<input type="checkbox"/> Abdominal pain <input type="checkbox"/> Bloating <input type="checkbox"/> Blood in stools <input type="checkbox"/> Change in stools <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn/reflux <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting
Neurological	<input type="checkbox"/> Dizziness <input type="checkbox"/> Extremity numbness/weakness <input type="checkbox"/> Headache <input type="checkbox"/> Lightheadedness <input type="checkbox"/> Memory loss <input type="checkbox"/> Seizures
Musculoskeletal	<input type="checkbox"/> Back pain <input type="checkbox"/> Bone/joint symptoms <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Neck pain
Ears/eyes nose/throat	<input type="checkbox"/> Ear drainage <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Itchy eyes <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye redness <input type="checkbox"/> Hoarseness <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Runny nose <input type="checkbox"/> Sinus pressure <input type="checkbox"/> Sneezing <input type="checkbox"/> Sore throat <input type="checkbox"/> Trouble swallowing
Cardiovascular	<input type="checkbox"/> Chest pain <input type="checkbox"/> Leg swelling <input type="checkbox"/> Murmur <input type="checkbox"/> Shortness of breath lying flat <input type="checkbox"/> Irregular heartbeat <input type="checkbox"/> Fainting
Metabolic/endocrine	<input type="checkbox"/> Cold intolerance <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Excessive hunger
Psychiatric	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Insomnia <input type="checkbox"/> Stress
Hematologic/lymphatic	<input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen glands <input type="checkbox"/> 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