MEDICAL HISTORY

Date of appointment _____

Name _____ Age _____ Sex M ☒ F ☐
Last First MI

Patient Race _____ Marital Status: ☒S ☐M ☐D ☐W
Patient Ethnicity _____
Primary Language (Spoken in household) _____

In your own words, briefly describe your symptoms and/or reasons for coming to Asthma and Allergy Associates:

_____

_____

_____

LIST YOUR CURRENT MEDICATIONS:
(include dose and how taken)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

IMMUNIZATIONS: (give dates)

DPT _____

MMR_____

Oral Polio _____

Hemophilus Influenzae b (Hib)_____

Influenza Vaccine _____

Pneumonia Vaccine _____

Tetanus Booster _____

Any reactions to above? Y ☐ N ☐
Describe_____
_____
_____
_____
_____
_____
_____
_____

Childhood Illnesses: (check those the patient has had)

☐ measles ☐ mumps ☐ rubella ☐ whooping cough ☐ rheumatic fever ☐ polio ☐ scarlet fever
☐ asthma ☐ hay fever ☐ recurrent croup ☐ bronchiolitis ☐ recurrent ear infections ☐ recurrent sinus infections

ADULT ILLNESSES	**DATE**	**OPERATIONS / INJURIES / HOSPITALIZATIONS**	**DATE**
_____		_____	
_____		_____	
_____		_____	
_____		_____	

List all medications you do not tolerate:	Medication:	Reaction:	Date:
	1. _____	**1.** _____	**1.** _____
	2. _____	**2.** _____	**2.**_____
	3. _____	**3.** _____	**3.**_____
	4. _____	**4.** _____	**4.** _____

List all foods you do not tolerate:	Food:	Reaction:	Date:
	1. _____	**1.** _____	**1.** _____
	2. _____	**2.** _____	**2.**_____
	3. _____	**3.** _____	**3.**_____
	4. _____	**4.** _____	**4**_____

SOCIAL HISTORY:

Please answer the following questions if you have used or are currently using tobacco products.

1. ☐ Current or ☐ Past Smoker
2. How long have/had you used tobacco products? _____
3. How much tobacco did/do you use per day? _____
4. Did/do you use? ☐ Cigarettes ☐ Cigars ☐ Pipe (check all that apply)
5. Past smokers – how long ago did you quit? _____

Do you drink alcohol? Y ☐ N ☐ How much? _____

How many caffeinated drinks do you consume per day? _____

Do you use illegal or recreational drugs? Y ☐ N ☐

What? _____ How Much? _____

FAMILY HISTORY:

	Name	Current Age	Age of death	Health problems	Cause of death
Parents					
Siblings					
Children					

Any history of the following in yourself or family? (Indicate relationship to you in space)

Hay fever	Y☐ N☒		Anemia	Y☐ N☐	
Asthma	Y☐ N☐		Hypertension	Y☐ N☐	
Hives	Y☐ N☐		Stroke	Y☐ N☐	
Atopic dermatitis (eczema)	Y☐ N☐		Heart disease	Y☐ N☐	
Chronic sinus problems	Y☐ N☐		Arthritis	Y☐ N☐	
Nasal polyps	Y☐ N☐		Diabetes	Y☐ N☐	
Bee allergy	Y☐ N☐		Epilepsy	Y☐ N☐	
Adverse drug reaction	Y☐ N☐		Headache	Y☐ N☐	
Cystic fibrosis	Y☐ N☐		Kidney disease	Y☐ N☐	
Chronic bronchitis	Y☐ N☐		Cancer	Y☐ N☐	
Tuberculosis	Y☒ N☐		AIDS/HIV	Y☐ N☐	

REVIEW OF SYSTEMS

Are you currently experiencing any problems with: (check box and check complaint)

Y☐ N☐ ☐ weight change ☐fatigue ☐fever ☐ headaches
Y☐ N☐ ☐ rashes ☐ lumps ☐ itching ☐ changes in skin, hair or nails
Y☐ N☐ ☐ double or blurred vision ☐ glaucoma ☐cataracts ☐ eye discharge
Y☐ N☐ ☐ earache ☐ hearing loss ☐ ringing in the ears ☐ dizziness ☐ ear discharge
Y☐ N☐ ☐ nosebleeds ☐ nasal stuffiness ☐ sinus trouble ☐ sinus infection
Y☐ N☐ ☐ bleeding gums ☐ gingivitis ☐tooth decay ☐hoarseness
Y☐ N☐ ☐ swollen glands ☐ lumps in neck ☐thyroid trouble
Y☐ N☐ ☐ cough ☐shortness of breath ☐wheezing ☐asthma ☐ phlegm
Y☐ N☐ ☐ high blood pressure ☐ heart trouble ☐ chest pain ☐ murmurs ☐rhythm disturbance
☐ strokes
Date of last: Chest x-ray _____ EKG _____ TB tine _____
Y☐ N☐ ☐ trouble swallowing stomach problems vomiting heartburn loss of appetite
Y☐ N☐ ☐ constipation ☐ diarrhea ☐ bloody or dark tarry stools ☐hemorrhoids ☐hepatitis
☐ liver or gallbladder disease
Y☐ N☐ ☐ burning or blood in urine ☐urinary frequency ☐ incontinence ☐ infections ☐stones
Y☐ N☐ ☐ varicose veins ☐ blood clots ☐ anemia ☐easy bruising/bleeding
Y☐ N☐ ☐ depression ☐mental illness
Y☐ N☐ **FEMALES:** ☐ venereal disease ☐PMS ☐menopause ☐ breast lumps/discharge
Date of last: Period _____ Mammogram _____
Method of Birth Control _____
Y☐ N☐ **MALES:** ☐ penile discharge/lesions ☐ venereal disease ☐ testicular pain ☐hernia
☐ breast lumps/discharge

PREVIOUS ALLERGY EVALUATION

Have you had a previous Allergy Evaluation (testing)? Y☐ N☐

Date	Doctor name & city	Problem
_____	_____	_____
_____	_____	_____
_____	_____	_____

Did you take allergy injections? Y☐ N☐ How long? _____

Were injections beneficial? Y☐ N☐

Did you have any problems with allergy injections? Y☐ N☐

Please explain: _____

_____

_____

_____

ENVIRONMENTAL SURVEY

How long have you lived in Colorado Springs? _____ Where did you previously live? _____

Do you live in the (check) ☐ city ☐ town ☐ rural?

HOME: Answer the following questions regarding the house you now live in.

Do you live in a single dwelling, duplex, townhome, apartment, mobile home, other? _____

How old is your home? _____ How long have you lived there? _____

(check all that apply for each of the following)

type of heating: ☐ forced air ☐ water ☐ oil ☐ electric ☐ woodburning stove ☐ fireplace
type of air conditioning: ☐ central air ☐ window unit ☐ swamp cooler ☐ none
type of air filter: ☐ HEPA ☐ electrostatic ☐ none Attached to furnace? ☐ Y ☐ N
type of humidifier: _____ Attached to furnace? ☐ Y ☐ N
Basement: ☐ damp ☐ dry ☐ finished ☐ unfinished ☐ none
Any recent water damage? ☐ Y ☐ N
Is there a greenhouse, houseplants? ☐ Y ☐ N How many plants? _____
Types _____
Do you have many? ☐ Cockroaches ☐ mice ☐ miller moths ☐ other insects?
_____
Are there smokers within the home? Y ☐ N ☐
Do they smoke in the home? Y ☐ N ☐
Are there pets? Y ☐ N ☐ Kind and how many of each _____
What percentage of time do they spend: outside _____% inside _____% patient's bedroom _____%
Do they sleep in patient's bedroom or on the bed? Y ☐ N ☐
How long has each pet been in the family? _____
_____
_____

PATIENT'S BEDROOM:

How often is it cleaned? _____ By whom? _____

Type of:
Floor covering _____
Furniture _____
Pillows _____

HOBBIES:
List hobbies and recreational activities _____
_____

WORK:
Present occupation _____ How long? _____
Past occupation _____ How long? _____
Do your symptoms ☐ improve / ☐ worsen at work?