MEDICAL HISTORY

Date of appointment _____

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

Patient Race _____ **Marital Status: Single☐ Married☐ Divorced☐ Widowed☐**

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 ALL CURRENT MEDICATIONS:
include dose and how taken, also include herbals, vitamins, over-the-counter medications and eye drops)

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

IMMUNIZATIONS: (give dates)

DPT _____

MMR _____

TB Tine _____

Oral Polio _____

Hemophilus Influenzae b (Hib) _____

Influenza Vaccine _____

Pneumonia Vaccine _____

Tetanus Booster _____

Any reactions to above? Y☐ N☐

Describe _____

Childhood Illnesses: (circle those the patient has had)

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

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

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

	Food:	Reaction:	Date:
List all foods you do not tolerate:	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 (please circle)
2. How long have/had you used tobacco products? _____
3. How much tobacco did/do you use per day? _____
4. Did/do you use? (check all that apply) Cigarettes ☐ Cigars ☐ Pipe ☐
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 at 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 circle 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 Southern Colorado? _____Where did you previously live? _____

Do you live in the (circle) 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? _____

(circle all that apply for each of the following)

type of heating: forced air, water, oil, electric, woodburning stove or 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 (circle) improve / worsen at work?