(adult)

Patient Name:_____ **Date:** _____
Date of birth:_____

I am being seen on:

a) self referral _____ b) physician referral from Dr. _____

Please share the main reasons for your office visit today (check all those that apply):

a) Allergic rhinitis (runny and/or stuffy nose) _____
b) Allergic conjunctivitis (red, itchy eyes) _____
c) Asthma _____
d) Bronchitis _____
e) Atopic dermatitis (eczema) _____
f) Nasal polyps _____
g) Urticaria (hives) _____
h) Frequent sinus infections _____
i) Other _____

What you would like to accomplish today?

a) Review my current illness and treatment _____
b) Obtain allergy testing _____
c) Obtain information on asthma diagnosis and treatment _____
d) Other _____

HISTORY OF PRESENT ILLNESS (please fill in all sections which apply to you or your family member):

My symptoms began :

____ days ago
____ weeks ago
____ months ago
____ years ago

My symptoms are

Seasonal: (Worse during a certain season? Check which season is worse)
Spring ____
Summer ____
Fall ____
Winter ____

Perennial (equal all year) with no seasonal change ____

Perennial (equal all year) with seasonal exacerbations in the:
Spring____ Summer ____ Fall____ Winter ____

Please check which of the following symptoms are present:

NOSE:
Nasal congestion (blockage) _____
Mouth breathing at night: _____
Itchy nose: _____
Bloody nose: _____
Sneezing: _____
Snoring: _____
Poor sense of smell: _____
Drippy/runny nose: _____
Drainage in back of throat: _____

LUNGS:
Wheezing: _____
Shortness of breath: _____
Cough: _____

EYES:
Redness: _____
Watering: _____
Sensitivity to light: _____
Itching: _____

HEADACHE:
Location (front, side, back) _____
Quality (sharp, dull, achy) _____

EARS:
Itching: _____
Congestion (stuffiness): _____
Frequent infections: _____

SKIN:
Hives: _____
Eczema: _____
Swelling of face: _____

Triggers that I know worsen my symptoms include:

No known environmental triggers _____

Specific environmental triggers:
- Indoor dust: _____
- Outdoor dust: _____
- Mold spores: _____
- Animal dander
  - cat ____
  - dog ____
  - other ____
- All pollens ____
  - tree pollen ____ grass pollen ____ weed pollen ____ other pollen ___

Non-specific environmental triggers:
- Weather changes
  - any weather change ____
  - hot and dry weather _____
  - cold and wet weather _____
- Tobacco exposure ____
- Perfumes and propellants ____
- Other _____
  _____

ALLERGY HISTORY:

Allergy testing has:
- never been pursued ____
- is scheduled ____
- has previously shown
  - no allergies ____
  - allergy to:
    - pollen ___
    - dust ___
    - mold ___
    - pets ___
    - other _____

I have never been on allergy injections ____

I am currently on allergy injections ____
- These began ____months ago
  ____years ago

I previously received allergy injections ____
- These were given ____years ago
- I continued these for ____years

Have you had experience with any of the following medications? If so, did they help?

TYPE OF MEDICATION	RESULT		EXAMPLES (i.e., Claritin, Flonase, etc.)
	GOOD	BAD	
Antihistamines	_____	_____	_____
Decongestants	_____	_____	_____
Antihistamine/Decongestants	_____	_____	_____
Nose sprays	_____	_____	_____
Eye drops	_____	_____	_____

Have you had allergic reactions to medications or foods?

DRUG REACTIONS:

Name of medication	Type of reaction (skin, respiratory, stomach symptoms, etc.)
1) _____	_____
2) _____	_____ –
3) _____	_____

_____

FOOD REACTIONS

Name of food	Type of reaction
1) _____	_____
2) _____	_____

PAST MEDICAL HISTORY

Hospitalizations and/or surgery:

Age or year for

_____ _____
_____ _____
_____ _____
_____ _____

Other chronic health conditions (Please specify)

_____
_____

Please list *all* of your current medications:

	Name of medication	Route, dose & frequency (i.e., 10mg each morning)	Indication (i.e., for blood pressure)
1)	_____	_____	_____
2)	_____	_____	_____
3)	_____	_____	_____
4)	_____	_____	_____
5)	_____	_____	_____

FAMILY HISTORY (Please check if your family member is or has been affected by the following illnesses):

	Asthma or Chronic bronchitis	Allergic rhinitis (hayfever)	Atopic dermatitis (eczema)	Urticaria (hives)
Mother	_____	_____	_____	_____
Father	_____	_____	_____	_____
Brother	_____	_____	_____	_____
Sister	_____	_____	_____	_____
Other relatives_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

SOCIAL HISTORY:

Occupational status

Occupation _____ Place of employment _____

unemployed ___
homemaker ___
retired ___
disabled ___
other _____
college student ___ school_____ classification_____ major_____

Marital status

single ____ widowed ____
married ____ other _____
divorced ____
separated ____

Number of children ____

Hobbies/recreation _____

Exercise
type of exercise _____
frequency (how often?) _____

TOBACCO HISTORY:

Cigarette smoker/or exposure (check all that apply)

Exposure to cigarette smoke _____

Non – smoker _____
Smoker _____ pack/day for _____ years

Ex-smoker _____
quit how long ago
weeks _____
months _____
years _____
Other tobacco use _____

ENVIRONMENTAL HISTORY:

The patient lives in a(n):
house ____
apartment ____
Other _____

The house is in:
town ____
the country ____

Indoor exposure to the following is present:

Pets:
cats _____
dogs _____
other _____

Heating/Air-conditioning:
central heat/air ____
evaporative cooler ____
gas heat/furnace ____
other _____

Bedding:
boxspring mattress ____
waterbed ____
other _____

Carpeting in bedroom ____
Other _____

ASTHMA *(Please skip this page if you have never had breathing problems)*

Asthma has:

never been previously diagnosed, but is suspected _____
been diagnosed in childhood _____ at age ____
been diagnosed in adulthood _____ at age ____

My compliance with medications:

is always excellent ____
is intermittently good ____
is poor because: ____
I hate to take any medication ____
I am concerned about side effects ____
medications are too expensive ____
medications have not helped me in the past____
other _____

I currently use the following:

a spacer attached to my inhaler ____
a peak flow meter to measure breathing ____
a written asthma action plan ____

Triggers for my asthma symptoms include:

no obvious exposures	____				
pollens	____	cigarette smoke	____	sinus infections	____
animal dander	____	weather change	____	exercise	____
dust	____	respiratory infections/colds	____	other_____	

Asthma medications I have had previous experience with include:

ASTHMA RELIEVERS	Response	
Long-acting	Good	Bad
Albuterol	____	____
Xopenex	____	____
Maxair	____	____
Atrovent	____	____
Combivent	____	____
Long-term		
Foradil	____	____
Serevent	____	____
ASTHMA CONTROLLERS		
Inhaled steroids		
Aerobid	____	____
Azmacort	____	____
Beclovent	____	____
Flovent	____	____
Pulmicort	____	____
Vanceril	____	____
Leukotriene modifiers		
Singulair	____	____
Accolate	____	____

Leukotriene modifiers (cont'd.)	Good	Bad
Zyflo	____	____
Mast cell stabilizers		
Intal	____	____
Tilade	____	____
Combination drugs		
Advair	____	____
Symbicort	____	____
Theophylline		
Slo-Bid	____	____
UniDur	____	____
Uniphyl	____	____
Oral Steroids		
Prednisone	____	____
Medrol	____	____
Prelone	____	____
Pediapred	____	____

*Other medications*_____