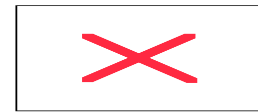
# The Allergy & Asthma Group, PC



Patient's Name: ______________________________ Age: _________ Date: _______________

Who referred you here? ________________Pharmacy and phone# ___________________________

What brings you to our office?____________________________________________________________

## Chief Complaints: (check the main symptoms)

**Head or nose symptoms**
____Sneezing
____Nose blocking
____Runny nose
____Postnasal drainage
____Sinus infections
____Sore throat
____Ear blocking
____Headache
____Eye symptoms

**Skin symptoms**
____Hives
____Eczema
____Itching

**Chest symptoms**
____Cough
____Wheezing
____Chest infections
____Shortness of breath
____Hoarseness or loss of voice

**GI**
____Acid reflux
____Throat clearing
____Heartburn
____Hives

**Other** ____________________________
___________________________________
___________________________________
___________________________________

Age when symptoms started:
Head or nose symptoms _________ Chest symptoms ______Skin symptoms ___________

Indicate the pattern of symptoms:

| | Head/Nose | Chest | Skin |
|---|---|---|---|
| Year round, no seasonal variation | ☐ | ☐ | ☐ |
| Year round, worse seasonally | ☐ | ☐ | ☐ |
| Seasonal only | ☐ | ☐ | ☐ |

If seasonal, list months ___________________________________________________________

## Past Medical History, Allergic:

Allergic to any drugs (penicillin, aspirin, or any others)? Yes No If so, list drugs:
_____________________________________________________________________________
_____________________________________________________________________________

List medicine used for allergy/asthma: _________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

List any other medication (including over-the-counter drugs, creams, suppositories, etc.) taken with any regularity:_________________________________________________________________
_____________________________________________________________________________
_____________________________________________________________________________

Describe any reactions to foods:_________________________________________________________
_____________________________________________________________________________

Have there ever been allergic symptoms from the sting of a bee, wasp, yellow jacket, or hornet, other than local swelling at the site of the sting (symptoms such as generalized itching, hives, swelling in areas remote from the sting, hay fever, asthma, nausea, vomiting, difficulty breathing, etc.)? Yes No

Has there been skin testing for allergy previously? Yes No
If so, give name, year and location of doctor doing the testing: _____________________________

Have "allergy shots" been used previously? Yes No If so, for how long? ___________________________

Patient's Name: ______________________________

Do your symptoms increase from any of the following?

**a. Allergens**

___Mowed grass ___House dust
___Dead grass ___Cats
___Dead leaves ___Dogs
___Hay ___Feathers

**b. Irritants**

___Smoke ___Outside dust
___Perfumes ___Paint
___Soaps ___Hair spray
___Detergents

**c. Weather Changes**

___Windy days
___Temperature/Weather change

**d. Foods (List):**

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

Indicate anything else you have noted that increase symptoms:

## Past Medical History, Other:

List surgeries or hospitalizations including nasal surgery / ear tubes / tonsillectomy / adenoidectomy:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

When was your last flu shot?

When was your last Pneumovax ("pneumonia shot")?

When was your last TB skin test?

Do you have migraines? yes no

Describe any reactions to latex or rubber:

*Pediatric patients only:* Are your childhood shots up to date? yes no
What was the birth weight?
Were there any complications at birth?

## Family History *(check if family members have any of the following: )*

| | Mother | Father | Siblings | Children | Relatives |
|---|---|---|---|---|---|
| **Asthma** | | | | | |
| **Hay Fever** | | | | | |
| **Sinusitis** | | | | | |
| **Eczema** | | | | | |

Do you have family members who are patients here at TAAG?

Name:______________________

Which doctor do they see?

______________________________

Patient's Name: ______________________________

# Environmental History

What city do you live in? ____________________How long?____________________________________

Previous Locations?______________________________________________________________________

**Home**

What kind of home do you live in: house / apt / mobile home How old is it?_____________

How long have you lived in current home?_________

Are you exposed to secondhand smoke? Yes No If yes, where: home/work/other

What kind of heat do you have: central / baseboard / portable gas

What kind of air conditioning do you have: central / window

How often do you change your air filters?

Please circle the one(s) you use: humidifier dehumidifier

Do you have a basement: Yes No Do you have a crawl space? Yes No

**Pets**: Are there pets at home? Yes No If so, what kinds? ___________________________

Kept outside completely ______ Outside some, inside some _____ Inside most of time ______

**Bedroom:** How old is your mattress? Do you use a dust mite cover? Yes No

What kind of pillow: Synthetic / Feather What kind of Comforter: Synthetic / Feather

Type of flooring: Carpet / Hardwood / Linoleum / Tile

# Occupational/Social History

Occupation *(if student, list school and grade):*

Do you smoke? Yes No If yes, how many packs per day and for how long?

If you are a previous smoker, how many years did you smoke?

How many days of work or school missed per year due to allergies/asthma/sinusitis?

Do your symptoms change at work / with hobbies / with fume exposure?

If patient is a child, is the child in daycare or with a sitter? How many days per week?

Patient's Name: ______________________________

# Review of Systems

Please check if you have/had problems related to the areas indicated.

| | YES | NO |
|---|---|---|
| **1. CONSTITUTIONAL** | | |
| Weight change | ❑ | ❑ |
| Fevers | ❑ | ❑ |
| Sweats | ❑ | ❑ |
| Fatigue | ❑ | ❑ |
| **2. EYES** | | |
| Glaucoma | ❑ | ❑ |
| Cataracts | ❑ | ❑ |
| Vision surgery | ❑ | ❑ |
| **3. EARS, NOSE, THROAT** | | |
| Loss of hearing | ❑ | ❑ |
| Dizziness | ❑ | ❑ |
| Hay fever | ❑ | ❑ |
| Sinus infections | ❑ | ❑ |
| Nose bleeding | ❑ | ❑ |
| Gum bleeding | ❑ | ❑ |
| **4. RESPIRATORY** | | |
| Chronic cough | ❑ | ❑ |
| Bronchitis | ❑ | ❑ |
| Shortness of breath | ❑ | ❑ |
| Asthma | ❑ | ❑ |
| Pneumonia | ❑ | ❑ |
| **5. CARDIOVASCULAR** | | |
| Heart attack | ❑ | ❑ |
| Chest pain/angina | ❑ | ❑ |
| Heart murmur | ❑ | ❑ |
| Anemia | ❑ | ❑ |
| Transfusions | ❑ | ❑ |
| Phlebitis or blood clots | ❑ | ❑ |
| Rheumatic fever | ❑ | ❑ |
| **6. GASTROINTESTINAL** | | |
| Acid reflux / Heartburn | ❑ | ❑ |
| Acid taste in mouth | ❑ | ❑ |
| Throat clearing | ❑ | ❑ |
| Blood in stools | ❑ | ❑ |
| Diarrhea | ❑ | ❑ |
| Constipation | ❑ | ❑ |
| Gall bladder disease | ❑ | ❑ |

| | YES | NO |
|---|---|---|
| **7. ENDOCRINE SYSTEM** | | |
| Diabetes | ❑ | ❑ |
| Thyroid problem | ❑ | ❑ |
| Hormone treatment | ❑ | ❑ |
| **8. BREAST/GENITAL** | | |
| Menopause | ❑ | ❑ |
| Masses | ❑ | ❑ |
| Genital infections | ❑ | ❑ |
| **9. URINARY SYSTEM** | | |
| Urinary tract | ❑ | ❑ |
| Bladder infections | ❑ | ❑ |
| Kidney stones | ❑ | ❑ |
| Incontinence | ❑ | ❑ |
| Trouble urinating | ❑ | ❑ |
| Prostate problems | ❑ | ❑ |
| **10. SKIN** | | |
| Cancers | ❑ | ❑ |
| Rashes | ❑ | ❑ |
| **11. NEUROLOGIC** | | |
| Stroke | ❑ | ❑ |
| Seizures | ❑ | ❑ |
| Head injury | ❑ | ❑ |
| Nerve damage | ❑ | ❑ |
| **12. PSYCHIATRIC** | | |
| Depression | ❑ | ❑ |
| Anxiety | ❑ | ❑ |
| **13. MUSCULOSKELETAL** | | |
| Osteoarthritis | ❑ | ❑ |
| Rheumatoid arthritis | ❑ | ❑ |
| Gout | ❑ | ❑ |
| **14. HEMATOLOGIC** | | |
| Anemia | ❑ | ❑ |
| Enlarged lymph nodes | ❑ | ❑ |
| Easy bleeding | ❑ | ❑ |

**OTHER** ______________________________
________________________________________
________________________________________
________________________________________
________________________________________

The information provided in this form is true and complete to the best of my knowledge.

Patient signature ______________________________________________________________

Updated (date) ____________________ *Form reviewed by physician:* ________________________

________________________________ *Date:* ___________________

rev 1/10/2012