Patients Full Name: ______________________________

Age: _______ Date of Birth: _________________ Gender: ________________

Address: ______________________________

Phone: ________________________ Preferred Method of Contact: Call Text MyChart

Single/Married/ Partnership/Divorced/Widowed (Please Circle)

Spouse name: ______________________ Phone: ______________________

Emergency Contact Persons Name: ______________________________

Relationship to Patient: ___________________ Emergency Contact Phone: ___________________

Primary Care Physician's Name: ______________________________

How did you hear about us? ______________________________

Please Complete the Following if Patient is Under 18 or a College Student

Mother's Full Name: ______________________________

Address: ______________________________

Home Phone: ______________________ Cell Phone: ______________________

Father's Full Name: ______________________________

Address: ______________________________

Home Phone: ______________________ Cell Phone: ______________________

With whom does the child reside? (Please circle) Mother/Father/Both/Other: ___________________

Form completed by Self, Parent/Guardian (Name): ______________________________

What questions do you hope to have answered from today's visit? ______________________________

____

How long have you had these problems? _________ How frequently do you have them? ____________

Allergy History

Nasal Symptoms/Causes (Please circle all that apply)

Nasal congestion	Nasal polyps	Loss of taste/smell
Nasal itch	Sinus infections	Discolored drainage
Post nasal drip	Irritability/fatigue	Bad Breath
Runny nose	Red eyes	Snoring
Sneezing	Itchy or watery eyes	Mouth breathing
Nose bleeds	Headaches	

What triggers your symptoms if known:

Dust	Cat	Home environment
Mold/Mildew	Dog	Workplace
Pollen- Fall or Spring or Both	Other animals ____________	Indoors
Cut grass/Raking leaves	Feathers	Outdoors
Smoke	Change in weather	Food___________________
Strong odors	Time of day- am/pm	

Other: ____

Do your symptoms occur year around or seasonally? (Please circle one)

If seasonally, which months: ____

Have you had sinus x-rays or CT scan? Yes No

Respiratory History

Cough	Shortness of breath
-with exercise	Tightness in chest
- during the night	Wheezing
- for weeks after cold	Cough from post nasal drip

Do you wake up at night due to chest symptoms? Yes No

If yes, times per week: __________________

Breathing problems triggered by:

Dusting or cleaning	Mowing grass/raking leaves	Hay/Straw/Barns
Pollen	Strong odors	Damp air
Aerosol sprays	Newspaper	Cold weather
Smoke	Exercise	Animals

Other:____

Were you ever diagnosed with asthma? If yes, when? ______________________________

Number of hospitalizations for asthma: ____________ Number of ER visits for asthma: ____________

Have you been on steroids or received a steroid shot for your asthma? No Yes If yes, how many times in the past year? ________________

Have you had a chest x-ray? Yes No Date: __________

Have you had CT scan? Yes No Date: __________

Have you had TB (PPD) test? Yes No Date: __________ Positive/Negative

Did you get a flu shot this year? Yes No Date: __________

-Pneumonia immunization? Yes No Dates: __________ __________

Current Medications

Please include nasal sprays, inhalers, prescriptions, over the counter, herbals, etc.

Name	Dose	Frequency	Is it effective?

Previous Allergy/Asthma Medication

Please include nasal sprays, inhalers, prescriptions, over the counter, herbals, ect. Please indicate side effects

____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________
____________	____________	____________	____________

Do you use a spacer with your inhaler? If yes, which type? ____________________

Do you own a home nebulizer? Yes No

Do you own a peak flow monitor? If yes, please list your best peak flow rate: ____________________

Previous Allergy History

Have you ever had allergy skin testing? If yes, please list the name of the physician and year:
Dr:____________________ Year: ____________________

Were you on allergy shots? If yes, when: ____________ Still on shots? Yes No

Did they help? Yes No __________% (0-100)

Reaction to allergy shots? If yes, please explain: ____________________

____

Environmental

Home Type: House Condo Apartment Mobile

Location: City Suburban Rural

Basement: None Full Crawl Space Damp Mold Dry

Air-treatment: Central Air/Window Forced Air Heat Hot Water Heat Wood Burner
Humidifier Central/Room Dehumidifier

How long have you lived there? ____________ How old is you home? ____________

Do you own pets? If yes, please specify: ____________________

Are your pets: indoor/outdoor/both

If you have pets do they sleep in your bed? Yes No

Bedroom

Is your bedroom located on the main floor or basement?

Type of bed? Regular Box spring/Pillowtop/Waterbed/Futon/Crib

Plastic encasement on mattress? Yes No On pillow? Yes No

What type of pillow do you use? Feather/Cotton/Synthetic

Are there any stuffed animals in bedroom? Yes No

What type of flooring do you have in bedroom? Carpet/Wood/Vinyl

Social History

What is patient's occupation? ____________________

Where and how long? ____________________

Are you a student? If yes, what grade? ____________________

Are your symptoms worse at work/school? If yes, please explain: ____________________

____

Please list your hobbies: ____________________

Have you traveled in the past year? If so, where ____________________

Do you get better when on vacation? Yes No

How many days of school or work did you miss in the past year due to allergies or asthma? ________

Do you have children in daycare? If yes, how many? ____________________

With how many other children? ____________________

Are there animals there? ____________________

Smokers? ____________________

Other relevant social factors: ____________________

____

Do you have a history of the following:

Blood transfusion HIV/AIDS Alcohol use Hepatitis Recreational drug use

Other: ____________________

Smoking (Please circle all that apply)

Current Smoker | Former Smoker, date quit____________ | Never Smoked

Packs/day ____________ | Packs/day______________

Years smoked __________ | Years smoked __________

Does anyone in the home smoke: Yes No | If so, Indoors Outdoors

Smoke exposure at work: Yes No

Vape ______________________________ Other:___________________________

Family History- Does any member of your family have a history of:

Asthma: ____

Allergies: ____

Frequent cough: ____

Who: (mother, father, sister(s), brother(s), grandmother(s), grandfather(s), # of children)?

Please list other chronic family conditions such as, hives, eczema, migraines, sinusitis, COPD, emphysema, immunodeficiencies, autoimmune disease ect. ____

____

Past Medical History- Hospitalizations

Illness	Date

Surgeries: Tonsillectomy Adenoidectomy Ear Tubes Sinus Surgery Other: ____________________

Do you have any allergies to: medications, foods, or latex? If yes, please explain:____

Chronic Health Conditions (Circle all that apply)

Hypertension, Heart disease, Diabetes, Migraines, Depression, GERD, Other: ______________________

Review of systems: Please circle all that apply

Constitutional: Fever, chills, weight loss, weight gain, heat/cold intolerance, headache

Eyes: itchy, watery, cataracts, glaucoma, drainage

Ears: decreased hearing/hearing loss, ringing in the ears, ear pain, multiple infections

Nose: decreased smell, congestion, runny nose, sneezing, nasal polyps, nose bleeds, multiple infections

Throat: Sore throat, itchy, hoarseness

Cardiovascular: chest pain or pressure, irregular heartbeat, racing heart, lower extremity swelling, pain in legs with walking

Respiratory: cough, sputum production, wheezing, shortness of breath, chest tightness

GI: abdominal pain, poor appetite, vomiting, diarrhea, heartburn, constipation

GU: frequent urination, painful urination, urgency, recurrent urinary tract infections

Musculoskeletal: joint pain or swelling, aching muscles, restricted motion, stiffness, back pain

Skin: rash, hives, itching, dryness, sores

Neurological: numbness or tingling sensation, loss of sensation, frequent headaches, double vision, weakness

Psychiatric: lack of energy, insomnia, irritability, nervousness, anxiety, depression, mood swings

Endocrine: heat or cold intolerance, frequent hunger, excessive thirst/urination

Hematologic: abnormal bleeding, easy bruising, anemia, unexplained swollen areas

Allergy/Immunology: seasonal allergies, hay fever symptoms, itching, swollen glands, exposure to HIV, recurrent infections

______________________________	____________________
Print Patient/Guardian Name	Relationship to Patient
______________________________	____________________
Patient/Guardian Signature	Date