ALLERGY, ASTHMA AND IMMUNOLOGY ASSOCIATES, P.C.

Medical History Review Today's Date:_____

Patient Name: _____ Date of Birth: _____
Referring Provider: _____ Primary Care Provider: _____
Other Providers: _____

1. Have we seen any family members at our office? Yes No
   If yes, please specify_____

2. What is the major problem(s) that brought you to our office? _____
_____
_____

3. How long have you had your symptoms? _____

Office use only

4. Do any of these trigger your symptoms? Please circle

Inhalants: Pollens Dust Mold Animals

Irritants: Fumes Odors Perfume Smoke

Ingestants: Food(s):_____

Infections: Respiratory Ear Sinus Bronchitis Pneumonia

Exercise: Shortness of Breath Cough Wheezing

Physical factors: Stress Weather change Temperature change Cold air Humidity

Work/School: Symptoms interfere with work/school Symptoms worsen with work/school

Insect: Reaction to Bees Yellow Jacket Wasp Hornet

Other: Reaction to Latex X-ray contrast dye

5. **Environmental History**: Please circle

Do you have any pets in the household? Cat Dog Other:_____

Type of flooring in your bedroom: Carpet Tile Wood

Does anyone in the household smoke indoors? Yes No

If patient is a child-- Does child attend daycare? Yes No

6. **Past Medical History**:

Do you have any health issues or chronic illnesses? Yes No
(high blood pressure, diabetes, heart conditions, arthritis, thyroid problems, cancer, anxiety, etc.)
If yes, please list

_____
_____
_____

Have you ever been hospitalized for anything other than surgeries? Yes No
If yes, please list reason for hospitalization and year it occurred

_____
_____
_____

7. **Past Surgical History**
Have you had any surgeries in your lifetime? Yes No
If yes, please list

_____
_____
_____

8. **Immunizations**
Are your immunizations up to date? Yes No

When was the last time you received these vaccines:
Tdap:_____ Td:_____ Pneumovax 23: _____ Prevnar 13: _____ Flu shot:_____

9. **Family History**
Do any immediate family members have any of the following conditions listed below? Yes No
If yes, please specify relationship to patient (*grandmother, father, sister, daughter, etc.*)
Allergies/Hayfever_____

Asthma_____

Eczema _____

Hives _____

Food Allergy _____

Immunodeficiency _____

Sinus Problems_____

10. **Social History**

Are you working? Yes No
If yes, list current employer and position: _____

Are you a student? Yes No
If yes, list current grade or year in school: _____

Are you currently using any tobacco products? Yes No
If yes, what type (*cigarettes, chewing tobacco, etc*) _____
# of packs per day_____ how many years used_____
If previous tobacco user, when did you quit_____
# of packs per day_____ how many years used_____

Any exposure to secondhand tobacco smoke? Yes No

11. **Medications** Preferred Pharmacy:_____

Are you allergic to any medications? Yes No
If yes, please list medication name and reaction that occurs
_____

Do you take any medications? Yes No
If yes, please list

Medication name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

12. **Review of Systems**

Please mark any of the following symptoms in each category that you have been experiencing. If no symptoms in that category, please mark "**none**"

General: ▢**None** ▢Fever ▢Fatigue ▢Recent weight loss ▢Recent weight gain ▢Pregnant

Eyes: ▢**None** ▢Itchy eyes ▢Watery Eyes ▢Red Eyes ▢Dry Eyes ▢Wearing glasses ▢Wearing contacts ▢Glaucoma

Ears: ▢**None** ▢ Ear Pain ▢Drainage from ears ▢Ringing in Ears ▢Itchy ears ▢Hearing loss

Nose: ▢**None** ▢Nasal Drainage ▢Post Nasal Drip ▢Congestion ▢Sneezing ▢Sinus Pain ▢Sinus Pressure

Throat: ▢**None** ▢Hoarseness ▢Sore Throat ▢Bad Breath

Lungs: ▢**None** ▢Shortness of Breath ▢Cough ▢Wheezing

Heart: ▢**None** ▢Chest Pain ▢Palpitations ▢Irregular Heart Rate

Stomach: ▢**None** ▢Cramps ▢Problems Swallowing ▢Heartburn ▢Nausea ▢Vomiting ▢Constipation ▢Diarrhea

Genitourinary: ▢**None** ▢Change in urinary frequency ▢Urinary Retention

Musculoskeletal: ▢**None** ▢Muscle Weakness ▢Severe Muscle Pain ▢Swelling of arms ▢Swelling of hands ▢Swelling of feet

Skin: ▢**None** ▢Rash ▢Hives ▢Eczema ▢Dry Skin ▢Itching ▢Skin Discoloration

Endocrine: ▢**None** ▢Heat intolerance ▢Cold intolerance

Lymph: ▢**None** ▢Glands in neck swollen ▢Easy bleeding ▢Easy bruising ▢Lymph node enlargement

Neuro: ▢**None** ▢Headaches ▢Dizziness ▢Tingling ▢Numbness

Psych: ▢**None** ▢Anxiety ▢Depression

_____ Drs. Initials