AAIC Asthma, Allergy & Immunology Center

**New Patient Visit**

DATE: \_\_\_\_\_\_\_\_\_ TIME IN: \_\_\_\_\_\_\_ TIME OUT: \_\_\_\_\_\_ ACCT#: \_\_\_\_\_\_\_\_

 Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Sex: M/F Married:

 Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Single:

 PCP/Referring M.D.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Referred by a friend/Self

 Local pharmacy of choice: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mail Order pharmacy: \_\_\_\_\_\_\_\_\_\_\_

 If a **minor**, accompanied by: (name) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Reviewed Medical Records from referring Physician/ PCP/ Specialists YES/NO**

**Drug Allergies: (Attach list)** **Food Allergies: (Attach list)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 **Current Meds: (Attach list) Previous Meds: (Attach list)**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

 **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

* Asthma meds (Circle what applies)
	+ Inhalers \_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Nebulizer \_\_\_\_\_\_\_\_\_\_\_­­­\_
	+ Singulair \_\_\_\_\_\_\_\_\_\_\_\_
* Allergy meds (Circle what applies)
	+ Nose sprays \_\_\_\_\_\_\_\_\_\_
	+ Antihist.\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ Eye drops \_\_\_\_\_\_\_\_\_\_\_
	+ Singulair \_\_\_\_\_\_\_\_\_\_\_\_
* Meds for Acid Reflux/Heartburn: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Meds for Hives/Swelling: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Meds/Creams/Lotions for Eczema/Atopic Dermatitis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Skin Test/Allergy Blood Test: Date: \_\_\_\_\_\_\_ By Whom: \_\_\_\_\_\_

 Allergy shots: \_\_\_\_\_\_\_\_\_\_ Stinging Insect \_\_\_\_\_\_\_ Fire Ant

 How long: \_\_\_\_\_\_\_\_\_\_ When stopped: \_\_\_\_\_ \_\_ Shots helping: Y/N

 Previous X-rays(Yes/No) CHEST/date: \_\_\_\_\_\_\_\_\_ SINUS/date: \_\_\_\_\_\_\_

 Previous CT Scans(Yes/No) CHEST/date: \_\_\_\_\_\_\_\_\_ SINUS/date: \_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_ ACCT# \_\_\_\_\_\_\_

CHIEF COMPLAINTS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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HISTORY OF PRESENTING COMPLAINTS:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_ACCT# \_\_\_\_\_\_\_

**PAST HISTORY: Circle all that applies:**

**GENERAL**

RECURRENT INFECTIONS

None

Recurrent ear infections? Yes/No

Recurrent sinus infections? Yes/No

Recurrent URI/LRI infections? Yes/No How many per year?\_\_\_\_

Recurrent pneumonias? Yes/No

Recurrent skin infections/ Abscess? Yes/No How many?\_\_\_\_\_\_\_\_\_

Other infections? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EAR INFECTIONS: Age of onset: How many per year: \_\_\_\_\_\_\_\_\_\_\_\_

Since when:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do infections clear quickly with antibiotics? Yes / No

Tubes in Ears: Yes/No (Dates): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many sets: \_\_\_\_\_\_\_\_\_ Did tubes help? Yes/No

 Vertigo/Imbalance: How long?\_\_\_\_\_\_\_\_\_\_ Meniere’s Disease: Yes/No

 Hearing Loss: Permanent /Intermittent. Hearing screening: Yes/No

 ADENOIDECTOMY/TONSILLECTOMY:

Speech: Appropriate / Delayed Speech Therapy: Yes/No

SINUS INFECTIONS: Age of onset: \_\_\_\_\_\_ How many per year: \_\_\_\_\_\_\_

Do infections clear with antibiotics? Yes / No

Sinus/Nasal polyps: Yes/No

Sinus surgery / irrigation: Yes/No How many times: \_\_\_\_\_\_\_\_\_

Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of ENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HEADACHES/Migraine : Yes/No Age of onset: \_\_\_\_\_\_ How often: \_\_\_\_\_\_\_\_\_\_\_\_

BRONCHIAL ASTHMA: Age of onset: \_\_\_\_\_\_\_\_\_\_ Well controlled: Yes/No

**Have you ever had (circle all that apply)**

Frequent ER visits: Yes/No Prior hospitalizations/ICU admissions: Yes/No

Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior intubations: Yes/No Prior oral steroid use: Yes/No

 Cough / wheeze / short of breath at rest / or with activity: Yes/No

 Lung Function Tests: Yes/No Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 By whom: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Aspirin /NSAIDs allergies: Yes/No Nasal/Sinus polyps: Yes/No

PNEUMONIA: How often: \_\_\_\_\_\_\_\_\_\_\_ Please give dates: \_\_\_\_\_\_\_\_\_\_\_\_

Right / Left / Both sides Chest x-rays/CT scans

# of hospitalizations: \_\_\_\_\_\_\_\_\_\_\_\_ Dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_ACCT #\_\_\_\_\_\_\_\_\_\_

**\*If you have Hives, fill out this page and proceed. If not, just proceed\***

**URTICARIA (HIVES)**

 **SKIP THIS SECTION IF YOU DO NOT HAVE HIVES**

* How long have you had hives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* First episode of hives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last episode? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How often do you break out into hives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Where do you break out in hives: Arms/Legs/Hands/Feet/Face/Torso/All over
* Size of hives: pin-head/dime/quarter/large/irregular/streaks/red: \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* How long do the hives last? Less than 12 hours/less than 24 hours/or several days? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What triggers the hives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do the hives itch? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Are the hives painful? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* When the hives go away, do they leave bruise marks? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you had lip, tongue or throat swelling, hand and feet swelling, nausea, vomiting or stomach pain along with the hives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* What medications have you tried for the treatment of hives: Atarax/ Benadryl/ Claritin/ Zyrtec/ Allegra/ Singulair/ Prednisone/ Pepcid/ Zantac \_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you have any body piercings? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Have you been to the ER for treatment of hives? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
	+ How many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last ER visit: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Do you also have: “colds/infections along with hives

Cold intolerance/ constipation/ weight gain

 Fatigue – how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Joint pain/ muscle pain \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Any hair loss/ mouth ulcers \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Large local reactions to mosquito or ant bites \_\_\_\_\_\_\_\_\_\_\_\_\_

* Family history of Lupus/ Rheumatoid Arthritis/ Sjogren’s \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Recent Blood tests/ Chest or Sinus X-rays / Colonoscopy/ Pap smear/ Mammogram/ PSA/ Skin biopsy/ Patch Test \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NURSE Physician

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_ACCT# \_\_\_\_\_\_\_

 **SURGICAL HISTORY:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOSPITALIZATIONS: EMERGENCY ROOM VISITS:**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PSYCHOSOCIAL:** (Home situation)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FAMILY HISTORY: (circle all that applies)**

 Do parents, grandparents, siblings, or children have the following:

Asthma Allergies Alpha-1 antitrypsin deficiency

Chronic infections Eczema/ Atopic Dermatitis Emphysema

Sinusitis Immune deficiency Thyroid disease

Cystic Fibrosis Sarcoidosis Diabetes

Hypertension Lupus Rheumatoid Arthritis

Heart Disease Cancer Alcoholism

 Depression Memory Loss Migraines

 **Travel History:**

 Any recent travel out of state or out of the country\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS: (Please circle the appropriate answer)**

GENERAL: Unexplained Weight (gain /loss) Fatigue Unexplained Fever

EYES: Itching Watering Burning Redness Dry

EARS: Popping Itching Ache Fluid PETs

 Imbalance Vertigo Wax Discharge

NOSE/ SINUS: Blocking Running Sneezing Sniffling Nasal/ Sinus Polyps Nose Bleeds Allergy salute Snoring

 Mouth Breathing/Dryness. Ansomia/Dysosmia

 Perennial Seasonal –Spring/Summer/Winter/Fall

THROAT: PND Itching Soreness Dry

 Hoarseness of Voice Bad breath

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_ACCT# \_\_\_\_\_\_\_\_

**(Please circle all that applies)**

NECK: Lymph node enlargement / pain Thyroid gland enlargement

HEADACHE: Frontal /Temporal/Top of Head/In between orbits Nuchal Pain Aura Triggers: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pounding/Dull/Throbbing Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Nausea/Vomiting with headaches? Yes/No Blurred vision: Yes/No

 Night / Early AM / Evening / All day Relieved with: \_\_\_\_\_\_\_\_\_\_\_

 CT / MRI of head Name of Neurologist: \_\_\_\_\_\_

CARDIAC: HBP Rheumatic Fever Heart murmur / MVP

 Chest pain Character of pain: Constant / Intermittent

 Radiation of pain Relation to respiration

 Palpitations Dyspnea/Orthopnea Past ECG or other heart tests

 Name of Cardiologist: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

LUNGS: Cough (dry/productive) Sputum: Color \_\_\_\_\_\_\_Quantity: \_\_\_\_\_\_\_\_\_\_\_

 Blood in sputum ( Y/N)

 Day: (with activity) / (without activity)

 Night: when laying down during sleep early morning

GI: Nausea / Vomiting Diarrhea / Constipation Appetite Abdominal pain

 Rectal bleeding Liver or gallbladder trouble Excessive belching

GU: Polyuria Nocturia Bladder Infections Stones

 Blood in urine LMP\_\_\_\_\_\_\_\_\_\_\_\_

MUSCULOSKELETAL: Muscle or joint pain Stiffness Arthritis Backache

HEMATOLOGIC: Anemia Easy bruising Past blood transfusions

ENDOCRINE: Thyroid problems Heat / Cold intolerance Diabetes

PSYCHIATRIC: Neuroses Mood Swing Depression Memory Loss

SKIN: Eczema Poison Ivy Rosacea Dry skin Atopic/Contact Dermatitis

 Hives

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB:\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_ACCT# \_\_\_\_\_\_\_

**BIRTH HISTORY / INFANT FEEDING/ PEDIATRICS:**

GESTATIONAL AGE: Term (37-42 wks) Pre Term (<37 wks) Post Term (>42 wks)

Complications: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birth weight: \_\_\_\_\_\_\_\_\_\_ Length: \_\_\_\_\_\_\_\_ Nursery Stay:\_\_\_\_\_\_\_\_\_\_

Assisted breathing: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FEEDING HISTORY: Breast Fed: Yes/No How many months? \_\_\_\_\_\_\_\_\_\_\_\_\_

 Formula fed/ supplemented (Yes/No)

 Milk based formula/Soy formula/Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Allergy to Formula/Baby Food/Table Food

DELIVERY: Normal C-Section

 Umbilical cord separation: Normal / Delayed (more than 6 weeks)

Rash at first month of birth: Yes/No

Growth and Development: Normal / Delayed

**(Provide immunization records)**

Immunizations : Up to date Yes / No - Requires \_\_\_\_\_\_\_\_\_\_\_\_\_

Prevnar /Pneumovax Influenza Varivax

**ENVIRONMENTAL / SOCIAL HISTORY:**

Alcohol/Drugs: Frequency: Duration of use:

House / Apartment / Mobile Home Carpet: Old / New

 Lived in for how long? fully / partially

 Location Rural / Urban Pets: Cats: in/out

Mattress: Encased Yes / No Dogs: in/out

Pillows: Feathered/Other Other: in/out

Bed Spread: Down/Poly fill Heat: Central

 Space Heaters

 Electric / Gas / Kerosene

Indoor plants: How many Air conditioning: Central / Window

Fan/Ceiling Fans Yes/No Filters changed frequently? Yes/ No

Venetian Blinds Drapes (Light/Heavy) Stuffed Animals? Yes / No

**If you are a NON SMOKER, SKIP this section.**

**Smoking History:**

**If you are a smoker, please fill out the questions below**

Tobacco use: \_\_\_\_\_\_\_\_ years

Smokes cigarettes? Yes/No If yes, how many packs a day? \_\_\_\_\_\_\_\_

Smokes pipe? Yes/No Uses chewing tobacco? Yes/No

Smokes Cigars? Yes/No Smoke marijuana: Yes/No

NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB:\_\_\_\_\_\_\_\_\_\_\_DATE: \_\_\_\_\_\_\_\_\_ACCT #\_\_\_\_\_\_\_\_\_\_

**Smoking History continued:**

**Have you**

Have you tried to quit? Y/ N

If yes, when did you quit? \_\_\_\_\_\_\_\_\_\_\_

If not, would you like to quit? Y/ N

**Second hand tobacco exposure**

None Minimal

Frequent Daily

Family member smokes indoors / in car Family member smokes outdoors only

Caregiver smokes indoors / in car Caregiver smokes outdoors only

**Occupation**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Years at current occupation: \_\_\_\_\_\_\_ Occupational exposure to Dust/Smoke/Irritants

# of work days missed this year: \_\_\_\_\_\_\_\_\_\_\_\_

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Outdoor activities: (\_\_\_\_\_\_\_%)

Attending Day Care since\_\_\_\_\_\_\_ How many days a week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# of children in class/group: \_\_\_\_\_\_\_\_\_

 School Grades: Good/Above Average/Average/Poor

# of school days missed this year:\_\_\_\_\_\_\_\_

 Has your illness impacted your quality of life: Yes/No

 If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nurse Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prem K. Menon, M. D. Date

FAAAAI, FACAAI, FAAP

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Vimla Menon, M. D. Date

 FAAAAI, FACAAI, FAAP