

Allergy & Asthma

of Southern Indiana, P.C.

Today's Date ___/___/___

Name _____

Age _____

Birth Date ___/___/___

How did you hear about us? Newspaper Bulletin Yellow Pages Calendar

Friend Hospital Other _____

Referring Physician _____

Family Physician _____

Chief complaint. Why are you here?

Length of symptoms? _____

Symptoms - Circle any symptoms you have had:

HEAD AND NECK

Eyes: itchy	watery	red
Ears: itchy	popping	plugged
Nose: itchy/rubbing	sneezing fits	runny - clear/white yellow green
stuffy/congested	snoring	mouth breathing
↓ or loss of smell/taste	frequent nosebleeds	dripping back of throat
Headaches: frontal	maxillary (cheekbones)	migraines

LUNGS

Shortness of breath ___ times/day, ? with exertion?
 Wake from sleep short of breath ___ times/week
 Difficulty breathing wheezing chest tightness
 Cough: at night? with exercise?
 sputum? clear/white yellow green

ASTHMA

Diagnosed at age _____
 Last hospitalized _____ Ever intubated? Yes No
 Proventil/ventolin use _____ times/day
 During past year: _____ # courses prednisone
 _____ # ER visits

Any CXR's?/CT sinus? - (when?)

Number of Infections past yr: Sinuses ___ Ears ___
 Bronchitis ___ Pneumonia ___
 No. of Antibiotics past yr. ___

SKIN

Hives/Urticaria Edema Itching Eczema

Are Hives associated with: Pressure from garments/belts/straps
 (circle) Insect bites infections
 Exercise contact with water
 Wind or strong breezes
 Scratching/stroking skin
 Family history of hives/edema

Foods _____
 Medicines _____
 Cold temperatures or contact with cold items
 Vibrations (mixers, jack hammer, other)
 Exposure to the sun/artificial light
 Swelling/Edema alone, without hives

STOMACH/INTESTINES

Indigestion/heartburn
Abdominal pain
Ulcers/gastritis

NEUROLOGIC/PSYCHIATRIC

Convulsions/seizures
Nervous or anxiety disorder
Depression

CARDIAC

Heart attacks
Heart failure

ENDOCRINE

Thyroid disease
Diabetes

MUSCULOSKELETAL

Arthritis
Muscle weakness

BLOOD/LYMPH

Anemia
Swollen lymph nodes

KIDNEYS/BLADDER

Frequent infections
Stones

OTHER

High blood pressure
Fatigue Weight loss
Fevers/chills 8/9/02

Name _____

- 2 -

DOB _____

Date _____

Circle if your symptoms are worse when exposed to:

Dust	Feathers	Dogs, Cats, other animals
Pollen	Grass cuttings	
Damp basements	Fallen leaves	Hay/Barnyards
Fumes	Smoke	Hair Sprays/Colognes

Circle times when symptoms are present:

Circle seasons when symptoms worsen:

Year Round Spring Summer Fall Winter

Spring Summer Fall Winter

Circle the factors that aggravate your symptoms:

Heat	Cold	Humidity	Weather changes
Exercise	Fatigue	Infections	

ENVIRONMENT

Type of home: House Mobile home Apartment Age of home _____ years old

How long have you lived there? _____

Where did you live before? _____

Do you have: (circle)	wall to wall carpet	area rugs	hardwood floors
	indoor plants	cloth furniture	mildew in any rooms
	basement:	dry damp	mildew/moldy smell
	crawl space under house		
Bed:	mattress	water bed	futon Feather: comforter/quilt
Pillows:	synthetic	feather	
Heating:	gas	electric	heat pump wood stove Other _____
Air conditioning:	none	central	window units

Do you humidify your home? Yes No Winter only Lake or pond near home: Yes No

List animals: In the home _____ Outside the home _____

Social History:

Birth: full term/ _____ weeks Breast until _____ months Bottle begun _____ months Solid food begun _____ months

Growth & Development: normal abnormal Immunizations: Up to date Late Attends daycare: Yes No

Occupation _____ Days of work/school missed per year _____

Smoke: _____ Never _____ pks/day x _____ yrs Quit: _____ yrs ago Other family members smoke? Yes No

Family allergies: (check)	<u>Asthma</u>	<u>Hay Fever</u>	<u>Eczema</u>	<u>Sinusitis</u>	<u>Ear Infections</u>
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Hereditary diseases: _____

Name _____

- 3 -

DOB _____

Date _____

Describe allergies to: Medications: _____

Insect Stings: _____

Foods: _____

PREVIOUS THERAPY

	Improved	Not Improved	Side Effects
<u>Antihistamines</u>	_____	_____	_____

<u>Decongestants/cold meds</u>	_____	_____	_____
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<u>Nose sprays/drops (list)</u>	_____	_____	_____
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_____	_____	_____	_____
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<u>Asthma medicines (list)</u>	_____	_____	_____
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<u>Inhalers</u>	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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<u>Prednisone/Medrol</u>	_____	_____	_____
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<u>Other</u>	_____	_____	_____
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<u>Accolate Singulair</u>	_____	_____	_____
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_____	_____	_____	_____
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Current Medications
(Include "over the counter" medicines)

PREVIOUS ALLERGY EVALUATION: Yes No

Have you ever had skin tests or allergy blood tests (RAST)? Yes No

When? _____ Doctor _____

Results of tests:

Have you ever been on allergy shots? Yes No Dates: _____ to _____ Did they help? Yes No

If shots were stopped, why were they stopped?

PAST MEDICAL HISTORY

Serious illnesses: _____

Hospitalizations: _____

Operations: _____
