

Patient Name: _____ Reviewed by: _____ Date: _____

WHAT BRINGS YOU TO OUR OFFICE TODAY?

- 1.
- 2.
- 3.

CURRENT SYMPTOMS:

1. EYES

- () Watery Eyes
- () Itching of the eyes
- () Swelling of the eyelids

2. EAR/NOSE

- () Sneezing
- () Runny nose
- () Blocked nose
- () Itching/rubbing of the nose
- () Post-nasal drip
- () Itching of the ears

4. THROAT/ CHEST

- () Coughing
- () Wheezing
- () Shortness of breath

5. SKIN

- () Rash
- () Swelling of the lips
- () Swelling of the body

6. STOMACH/GI

- () Nausea/stomach cramps
- () Diarrhea

7. NEURO

- () Headache

8. WORSE SEASON

SUMMER/SPRING/FALL/WINTER

MEDICAL HISTORY:

- () Ear infections
- () Hay fever/Allergy
- () Allergy skin tests, date: _____
- () Allergy injections, date: _____
- () Sinus infection
- () Asthma/croup/ Bronchitis/Pneumonia
- () Hives/Skin rashes/eczema

How would you describe your diet?

EXCELLENT: 5-6 Pieces of fruit/veggies

Low fat, high fiber, low meat

FAIR: 1-2 fruit/veggie/low fat

POOR: Typical Western diet

Fast food, hydrogenated fats

Have you ever had?

- () Chicken Pox
- () Herpes () oral () genital
- () Problems with vision/hearing
- () Heart disease/High blood pressure
- () Diabetes/Thyroid disorder
- () Liver disease/Hepatitis
- () Lung infections
- () Serious infections
- () Nervous system disorders
- () Stomach/intestinal disorders
- () Psychiatric evaluation/medicine

- () Reaction to foods *
 - () Reaction to medicines *
 - () Reaction to insects stings *
- PLEASE DESCRIBE:

MEDICATIONS, CURRENT/PAST

(CURRENT)	(PAST)
_____	_____
_____	_____
_____	_____
_____	_____

IMMUNIZATIONS RECEIVED/ UTD

- () Pneumonia Shot
- () Varicella/ Chicken Pox
- () H1N1/ Flu Shot
- () TB Test () Pos () Neg

FAMILY HISTORY

Do any of your relatives have?

Hay fever, Asthma, eczema

- () Mother () () ()
- () Father () () ()
- () Grandparents(s) () () ()
- () Sister(s) () () ()
- () Brother(s) () () ()
- () other relatives () () ()

Do any of your relatives have?

- () Emphysema () Cystic Fibrosis () Lung disease

SOCIAL HISTORY

Job: _____

Hobbies: _____

Ethnic Origin: _____

() Menopause: last period _____

Air travel/ rare /occasional /often

SMOKING/EXPOSURE

() In house/Car/At work

() Second Hand Smoke

#Cig/Day ___ Yrs smoking ___ Last smoked ___

Alcohol/drugs

of drinks/beer/wine per week _____

Caffeinated Beverages

1-2/cups a day # 2-3 #3-4

HOME ENVIROMENT

Locale1) Area/Town/City _____

Approx age of structure _____

Locale 2)

Area/Town/City _____

Approx age of structure _____

Locale1 Locale2

- Central air cond. () ()
- Window air cond. () ()
- Swamp cooler () ()
- Central heating () ()
- Fireplace/stove () ()
- Flooding/Mold () ()
- Humidifier () ()

In your Bedroom, indicate what applies:

- Floor:
- Carpet () ()
- Wood () ()
- Tile () ()
- Window covering:
- Curtains () ()
- Shades () ()
- Mini-blinds () ()
- Bed:
- Mattress/Bxspring () ()
- Water bed () ()
- Other: _____

- Pillows:
- Feather () ()
- Poly () ()
- Foam () ()
- Stuffed animals () ()
- Books () ()
- Plants () ()
- Pet(s):
- Cat(s) how many () ()
- Dog(s) how many () ()
- Bird(s) how many () ()
- Other _____

Amount of time the pet(s) is (are):

- Indoor % of time () ()
- Outdoor % of time () ()
- % of time/bedroom () ()