Patient Name:	Referred by:	
WHAT BRINGS YOU TO OUR OFFICE?	1	
1.		
-		
2.		
CURRENT SYMTOPMS:	( ) Serious Infections	SMOKING/EXPOSURE
EYES	( ) Heart disease/High blood pressure:	( ) In house/Car/At work
( ) Watery Eyes		( ) Second Hand Smoke
( ) Itching of the eyes		#Cig/Day Yrs smoking Last smoked
( ) Swelling of the eyelids	( ) Endocrine(Diabetes/Thyroid/Etc.) Disorder:	
EAR/NOSE	( ) Endocrine(Blabetes) Thyrold, Etc., Bisorder.	HOME ENVIROMENT
( ) Sneezing		Locale1) Area/Town/City
( ) Runny nose	( ) Reaction to foods *:	Approx age of structure
( ) Blocked nose	( ) <u>neaction</u> to roots .	Locale 2)
( ) Itching/rubbing of the nose ( ) Post-nasal drip		Area/Town/City
( ) Itching of the ears	( ) Reaction to medicines *:	Approx age of structure
1. Past surgery (ear) (nose) (throat)	( ) <u>Reaction</u> to medicines .	
2. Sense of smell last 6 months		<u>Locale1</u> <u>Locale2</u>
Poor 12345678910 great	( ) 0	Central air cond. ( ) ( )
THROAT/ CHEST	( ) <u>Reaction</u> to insects stings *:	Window air cond. ( ) ( )
( ) Coughing		Swamp cooler ( ) ( )
( ) Wheezing		Central heating ( ) ( )
( ) Shortness of breath	MEDICATIONS AND SUPPLEMENTS	Fireplace/stove ( ) ( )
( ) Past Pneumonia	(CURRENT) (PAST)	Flooding/Mold ( ) ( )
SKIN		Humidifier ( ) ( )
( ) Rash		
( ) Swelling of the lips ( ) Swelling of the body		In your Bedroom, indicate what
STOMACH/INTESTINAL		applies:
DISORDER		Floor:
( ) Nausea/stomach cramps		Carpet () ()
( ) Diarrhea		Wood /Tile () ()
( ) Lactose Intolerant		Window covering:
( ) Wheat/Gluten Sensitivity		Curtains () ()
( ) Celiac Disease	IMMUNIZATIONS RECEIVED	Shades/Blinds ( ) ( )
( ) Liver Disease	( ) Pneumonia Vaccine Year:	Bed:
	( ) Varicella/ Chicken Pox Year:	How old is your mattress?
NEUROLOGIC DISORDERS	( ) H1N1/ Flu Shot Year: ( ) TB Test ( ) Pos ( ) Neg / Blood QF Gold	0-5 years / 5-10 years / >10 years
( ) Headache	FAMILY HISTORY	Pillows:
( ) Headache	Do any of your relatives have?	Feather () ()
	( ) Emphysema ( ) Cystic Fibrosis ( ) Lung disease	Poly ( ) ( )
Gynecologic Issues	Howfover Asthma acroma	Foam () ()
( ) Menopause: last period	Hay fever, Asthma, eczema	Stuffed animals on Bed?
( ) Hysterectomy	* * * * * * * * * * * * * * * * * * * *	0 /1-2 />2-10
( ) Hormone Replacement		Books () ()
WORSE ALLERGY SEASON	( ) Grandparents(s) ( ) ( ) ( )	Plants () ()
SUMMER / SPRING/ FALL/ WINTER	( ) Sister(s) ( ) ( ) ( )	Pet(s):
How often do you have?	( ) Brother(s) ( ) ( ) ( )	• •
( ) Ear infections/Sinus infection	( ) other relatives ( ) ( ) ( )	, , , , , , , , , , , , , , , , , , , ,
Have you ever had?	SOCIAL HISTORY	Dog(s) how many ( ) ( )
( ) Allergy skin tests, date:	Ethnic Origin:	Bird(s) how many ( ) ( )
( ) Allergy injections, date:	Job:	Other
( ) Asthma/croup/ Bronchitis/Pneumonia ( ) Hives/Skin rashes/eczema	Hobbies:	Amount of time the pet(s) is (are):
( ) Chicken Pox ( ) Shingles	Air travel/ rare /occasional /often	Indoor % of time () ()
( ) Herpes ( ) oral ( ) genital	Stress rate in the Last 6 months	% of time/bedroom ( ) ( )
( ) Problems with vision/hearing	Least 12345678910 Most	