Allergy and Asthma Specialty Center, Inc
Patient History Form

Name:_____ Date of Birth:_____ Date of Visit:_____

Briefly describe the reason for your visit:

_____

How long have you had these problems? _____ How frequently do you have them? _____

ALLERGY HISTORY

NASAL SYMPTOMS

1. I have the following symptoms (circle all that apply)

Nasal congestion	Nasal itch/rub	Bad breath
Fatigue/irritability	Red eyes	Snoring
Post nasal drip	Itchy eyes	Mouth breathing
Runny nose	Sinus infections	Nose bleeds
Sneezing	Discolored drainage	Loss of taste/smell
Nasal polyps	Headaches	Sore throat

2. Circle all the things that trigger your symptoms

Dust	Mold/mildew	Time of day am/pm
Fall pollen	Mustiness/dampness	Home
Springtime pollen	Indoors	Workplace
Cut grass/rake leaves	Outdoors	Food
Dog	Weather changes	Rain
Cat	Smoke	Aspirin/ibuprofen
Other animals_____	Strong odors	
Feathers	Temperature changes	

Do your symptoms occur year round or seasonal? (circle one or both)
If seasonal, month symptoms occur_____

3. Have you had a sinus x-ray or CT scan? Yes No If yes, when? _____
4. Have you seen an ENT doctor or had sinus surgery in the past? Yes No
   If yes, when? _____

RESPIRATORY HISTORY

1. I have the following symptoms (circle all that apply)

Cough	Shortness of breath	Cough from post nasal drip
Chest tightness	Wheezing (noise from chest)	Symptoms with exercise

If you circled any of the above symptoms, answer questions 2-8

2. Do you wake up at night because of your symptoms? Yes No
   If yes, how many times per week/month? _____
3. Did you have problems with your breathing at birth? Yes No
   If yes, explain_____

4. Breathing problem is triggered by (circle all that apply)

Pollen	Exercise	Rain	Pets
Mold	Heartburn	Cold weather	Sinus infections
Foods	Weather change	Colds	Other_____

5. My breathing problem or asthma has been associated with (circle all that apply)
   ER visit Hospitalization Intubation Pneumonia ICU admission
   If you circled any of the above, indicate how many times in the past year_____
6. Have you been on steroids or received a steroid shot for asthma? Yes No
   If yes, how many times in the past year? _____
7. Have you had a chest x-ray or CT scan Yes No If yes, when? _____
8. Do you get recurrent infections? (circle all that apply)
   Sinus infections Pneumonia/bronchitis Ear infections Other_____
   If you circled any of the above, indicate how many times in the past year_____

URTICARIA/ANGIOEDEMA

(Only fill out if you have hives and swelling)

1. How long have you had hives/swelling? _____
2. Briefly describe the circumstances surrounding their onset?
   _____
   _____
   _____
   _____
3. How often do you have hives or swelling? _____
4. What triggers the hives/swelling? (circle all that apply)

Stress	Vibration	Food _____	Cold
Friction	Home	Sunlight	I don't know
Work	Heat	Sweat	Medication
Water	Exercise	Pressure	Other _____

5. What medications are you taking or have taken for hives/swelling? _____
   _____
6. How long does each individual hive last? Less than 24 hours Greater than 24 hours
7. Do they itch? Yes No
8. Are they painful? Yes No
9. Do you experience shortness of breath, wheezing, chest tightness, abdominal pain, throat fullness, dizziness or diarrhea? (circle symptoms) Yes No
10. Have you recently experienced fever, chills, night sweats, swollen glands, swollen joints, weight gain or weight loss? (circle symptoms) Yes No
11. Do you have a family history of hives/swelling? Yes No
    If so, who? _____
12. Do you have a history of hives/swelling in the past? Yes No
    If yes, when and how long did they last? _____

ECZEMA/RASH

(Only fill out if you have eczema or rash/dermatitis)

1. Where is your rash located? _____
2. What triggers your rash (circle all that apply)

Stress	Clothing	Dogs	Foods _____
Heat	Perfume/fragrance	Creams/lotions	Latex/rubber
Cold	Cats	Grass	

3. Have you had patch testing? Yes No If yes, when? _____
4. What medication or creams do you use for the rash? _____
5. Have you been on oral or injectable steroids? Yes No
6. Have you seen a dermatologist? Yes No If yes, when? _____
   If yes, was a skin biopsy performed? Yes No

INSECT ALLERGY

(Only fill out if you have allergic reaction to insect stings)

1. My reaction to an insect sting occurred on? Month_____ Year_____
2. Please describe the location of the sting and what happened at the time of the sting?
   _____
   _____
   _____
3. What caused the sting? Bee Wasp Hornet Yellow Jacket Ant Unknown

4. The symptoms that occurred after the sting include (circle all that apply)

Swelling at the site	Trouble breathing	Throat swelling
Distant swelling	Trouble swallowing	Shock
Hives	Vomiting	
Loss of consciousness	Dizziness	

5. Did you receive treatment at an emergency room? Yes No
   If yes, they gave me: Benadryl IV fluids Epinephrine Steroids Don't know
6. I have an Epipen Yes No
7. Have you been stung before? Yes No
   If yes, when and describe the reaction _____

FOOD ALLERGIES

(Only fill out if you have food allergy or suspect food allergy)

1. Are you allergic to any foods?

Food	Reaction	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Do you have trouble swallowing due to foods or were diagnosed with eosinophilic esophagitis?
   Yes No
   If yes, did you have an endoscopy by a GI doctor and when? _____
3. Do you have an Epipen? Yes No

MEDICAL/SURGICAL HISTORY

1. Do you have any of the following medical problems? (circle all that apply)

High blood pressure	Kidney problems	Reflux/GERD	Thyroid disease
Diabetes	Heart disease	Cancer	Stroke

Other _____

2. Hospital stays

Date	Reason
_____	_____
_____	_____

3. Surgeries

What surgeries and what year? _____

_____

Tonsils removed Sinus surgery Adenoids removed Ear tubes

4. Have you had a previous allergy evaluation? Yes No

   If yes, when? _____ What was the result? _____

5. Were you on allergy shots before? Yes No

   Did they help? Yes No

   What year did you start them and when did you stop? _____

6. Have you had all of your childhood immunizations? Yes No
7. Have you had Pneumovax/Prevnar vaccine (circle all that apply)? Yes No
8. Do you get the flu shot every year? Yes No

MEDICATIONS

1. I take the following allergy/asthma medications, inhalers and nose sprays:

Name	Dose	Frequency used
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other medications

_____	_____	_____
_____	_____	_____
_____	_____	_____

2. Do you use a spacer with your inhaler? Yes No

   Do you have a peak flow meter? Yes No If yes, best peak flow rate is _____

3. Do you own a nebulizer? Yes No

MEDICATION ALLERGIES

1.

Medication	Reaction	Date
_____	_____	_____
_____	_____	_____

_____ _____ _____

2. Do you have latex allergy? Yes No

SOCIAL/ENVIRONMENTAL HISTORY

GENERAL

1. Do you have a smoking history? Yes No
   If yes, how much per day? _____
   How many years? _____
   When did you stop? _____
2. Do you drink? Yes No If yes, how much per week? _____
3. Any recreational drug use? Yes No
4. Where do you live (please circle) House Apartment Trailer Condo Other_____
5. How long have you lived there? _____ How old is it? _____
6. How long have you lived in California? _____
7. Where else have you lived? _____
8. Pets (please specify) Yes No
   Cat Indoor/outdoor/bedroom
   Dog Indoor/outdoor/bedroom
   Other Indoor/outdoor/bedroom
9. Smokers in the house? Yes No
10. Is your home air conditioned? Yes No
11. Do you have a swamp cooler? Yes No
12. Do you have a humidifier? Yes No
13. Do you have an air filter? Yes No If yes, where? _____
14. Do you have moisture problems in your home? Yes No
15. Any known mold problems? Yes No
16. Type of bed? Regular Waterbed
17. Plastic or dust mite proof encasement on mattress? Yes No On pillow? Yes No
18. Stuffed animals in bedroom? Yes No
19. Type of pillow: Feather Synthetic Cotton
20. Flooring (circle all that apply): Wood Vinyl Carpet Area rugs

WORK/SCHOOL

1. What is your occupation? _____
2. If a student, what grade are you in? _____
3. What are your hobbies? _____
4. Do you have worse symptoms at work? _____
5. Do you get better on vacation? _____
6. How many days did you miss school or work in the past year? _____
7. If child, is he/she in daycare? Yes No

FAMILY HISTORY

Does any member of your family have a history of (circle all that apply):

Asthma Mother Father Brother Sister Son Daughter Grandparent

Hay fever Mother Father Brother Sister Son Daughter Grandparent

Eczema	Mother Father Brother Sister Son Daughter Grandparent
Food allergy	Mother Father Brother Sister Son Daughter Grandparent
Recurrent infections	Mother Father Brother Sister Son Daughter Grandparent
Other lung disease	Mother Father Brother Sister Son Daughter Grandparent
Swelling disorders	Mother Father Brother Sister Son Daughter Grandparent
Hives	Mother Father Brother Sister Son Daughter Grandparent
Other _____	Mother Father Brother Sister Son Daughter Grandparent

REVIEW OF SYSTEMS

Please circle any appropriate complaints

Constitutional: fever weight loss/gain fatigue irritability chills

Eyes: Swelling around eyes discharge redness itching blurred vision pain

HENT: Hearing loss recurrent ear infections ringing in ears fullness In ear sore throat

Cardiac: Palpitations chest pain high blood pressure heart disease

Respiratory: Shortness of breath cough sputum

GI: Nausea vomiting diarrhea constipation blood in stool heartburn

GU: Burning on urination pain on urination frequent urination pregnancy blood in urine

Musculoskeletal: Muscle pain back pain joint pain/swelling joint stiffness

Skin: Rash itching

Neurologic: Headache dizziness loss of consciousness paralysis numbness slurred speach

Psychiatric: Depression anxiety psychosis

Hematologic: Anemia bruising bleeding

Lymphatic: Enlarged lymph nodes splenectomy

Endocrinologic: Sweating cold/heat intolerance frequent drinking frequent urination