NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_

REFERRED BY (IF PHYSICIAN PLEASE PROVIDE ADDRESS/PHONE):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIMARY CARE PHYSICIAN (NAME/ADDRESS/PHONE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FORM COMPLETED BY\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELATIONSHIP TO PATIENT\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICATIONS** **MEDICATION REACTIONS/CONTACT ALLERGIES**:

(PRESCRIPTION/OTC/HERBAL/SUPLLEMENTS): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ IV CONTRAST REACTION? Y N N/A

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BEE/WASP STING REACTION? Y N

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BANDAGES/MEDICAL TAPE Y N

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ CHEMICAL/POISON IVY Y N

**MEDICAL HISTORY**: **SURGERIES** (TYPE AND DATES):

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

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

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

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

**FAMILY HISTORY** (CHECK BOX IF FAMILY MEMBER HAS BEEN DIAGNOSED WITH DISEASE):

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
|  | MOTHER | FATHER  | SIBLING  | GRANDPARENT  | CHILD | OTHER |
| ALLERGIES (NASAL/EYE) |  |  |  |  |  |  |
| ASTHMA |  |  |  |  |  |  |
| ECZEMA |  |  |  |  |  |  |
| FOOD ALLERGY |  |  |  |  |  |  |
| DRUG ALLERGY |  |  |  |  |  |  |
| HIVES |  |  |  |  |  |  |
| IMMUNE PROBLEMS |  |  |  |  |  |  |
| HEART DISEASE |  |  |  |  |  |  |
| THYROID DISEASE |  |  |  |  |  |  |
| DIABETES |  |  |  |  |  |  |
| CANCER  |  |  |  |  |  |  |
| OTHER |  |  |  |  |  |  |

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REASON FOR VISIT** (DESCRIBE SYMPTOMS AND COMPLAINT):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

HOW LONG HAVE YOU HAD THIS PROBLEM?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW OFTEN DOES IT OCCUR? (TIMES PER DAY, WEEK, ETC)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW LONG DOES IT LAST?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ANY TIME OF YEAR IT IS WORSE? (OR CIRCLE THE MONTHS MOST SEVERE)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

JANUARY FEBRUARY MARCH APRIL MAY JUNE JULY

AUGUST SEPTEMBER OCTOBER NOVEMBER DECEMBER ALL YEAR

WHAT MAKES IT WORSE? (ENVIRONMENT (DAMP/DRY, INDOORS/OUTDOORS,EXERCISE, ANIMALS,ETC):

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

WHAT MAKES IT BETTER?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

MEDICATIONS YOU HAVE TRIED? (ANTIHISTAMINES, NASAL STEROIDS, INHALERS, ANTIBIOTICS)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

**PAST ALLERGIC/INFECTIOUS HISTORY** (IF YES, PLEASE EXPLAIN)

NASAL ALLERGIES \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EYE ALLERGIES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ASTHMA\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ECZEMA (ATOPIC DERMATITIS)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HIVES\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SWELLING (ANGIOEDEMA)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

THROAT CLOSURE OR FULL BODY ALLERGIC REACTION (ANAPHYLAXIS)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

REACTIONS TO FOODS:

MILK:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EGGS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

WHEAT:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SOY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PEANUTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TREENUTS/SEEDS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SEAFOOD (FISH):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SHELLFISH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

INFECTIONS: (IF SO, HOW MANY TIMES PER YEAR)

SINUSITIS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

EAR INFECTIONS (OTITIS MEDIA)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PNEUMONIAS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SKIN INFECTIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

URINARY TRACT INFECTIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

FREQUENT BOWEL INFECTIONS\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

OTHER\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PREVIOUS ALLERGY TESTING? Y N IF SO, RESULTS? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALLERGY SHOTS? Y N

PRIOR PULMONARY FUNCTION TESTS? Y N IF SO, RESULTS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PRIOR CT/SCANS/XRAYS OF SINUSES/CHEST Y N IF SO, RESULTS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED (CIRCLE ONE)

SMOKING HISTORY: \_\_\_\_\_\_\_YEARS \_\_\_\_\_\_\_\_PACKS/DAY SMOKELESS TOBACCO: \_\_\_\_\_\_\_ \_\_\_

 E-CIGS: \_\_\_\_\_\_\_\_ MARIJUANA:\_\_\_\_\_\_\_\_\_OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ QUIT ?\_\_\_\_\_\_\_\_\_\_IF SO, WHEN?\_\_\_\_\_\_\_\_

PASSIVE SMOKE/2ND HAND SMOKE EXPOSURE: \_\_\_\_\_\_\_\_\_IF USING TOBACCO, WOULD YOU LIKE TO QUIT? \_\_\_\_\_\_\_\_

ALCOHOL : \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/WEEK

CAFFEINE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_/DAY

OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ HOW LONG?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOBBIES/SPORTS \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ENVIRONMENTAL HISTORY**:

HOME: SINGLE FAMILY HOME TOWNHOME APARTMENT CONDO OTHER

AGE OF HOME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ YEARS OF OCCUPANCY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

BASEMENT: Y N IF SO, ANY MOISTURE PROBLEMS?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AIR CONDITIONING: NONE CENTRAL ROOM UNIT SPACE PACK

HEATING: FORCED AIR RADIANT RADIATOR

PORTABLE HUMIDIFER Y N IF SO, HOW IS IT CLEANED \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

TOBACCO SMOKE EXPOSURE Y N IF SO, EXPLAIN FREQUENCY \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SIGHT OR SMELL OF MOLD? Y N IF SO, EXPLAIN\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PETS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ BREED:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

HOW LONG?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ALLOWED INTO BEDROOM? Y N

REGULAR PET EXPOSURE OUTSIDE OF THE HOME? Y N

BEDROOM:

FLOORING IN BEDROOM:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_WINDOW TREATMENTS:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

PILLOWS: SYNTHETIC DOWN/FEATHER COTTON FOAM

COMFORTERS: SYNTHETIC DOWN/FEATHER COTTON OTHER

USE OF DUST MITE ENCASEMENTS: Y N

NAME\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DOB\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PLEASE CIRCLE THE SYMPTOMS THAT APPLY TO YOU**:

HEAD AND NECK:

EYES: ITCHY RED SWOLLEN DRAINAGE

EARS: PAIN CLOGGED DECREASED HEARING

NOSE: CONGESTION SNEEZING ITCHING DRIPPING LOSS OF SMELL BLEEDING PAIN

THROAT: PAINFUL IRRITATED HOARSENESS CLEARING BURNING

RESPIRATORY:

SHORTNESS OF BREATH COUGH WHEEZING TIGHTNESS CHEST CONGESTION

CARDIOVASCULAR:

PALPITATIONS MURMUR SKIPPED OR IRREGULAR HEARTBEAT CHEST PAIN/ANGINA

ELEVATED BLOOD PRESSURE CLOTTING OF THE ARTERIES OR VEINS CHEST PAIN DURING EXERTION

GASTROINTESTINAL:

NAUSEA VOMITING DIARRHEA HEARTBURN FOOD IMPACTION (STUCK WITH SWALLOWING)

ABDOMINAL PAIN CRAMPING CONSTIPATION BLOOD IN STOOLS

SKIN:

RASH SWELLING HIVES ECZEMA PSORIASIS ITCHING BURNING CHANGE PIGMENT/ TEXTURE

MUSCULOSKELETAL:

JOINT ACHES MUSCLE SORENESS SWELLING WEAKNESS ARTHRITIS

NEUROLOGIC/PSYCH:

HEADACHES DIZZINESS VERTIGO TINGLING NUMBNESS DEPRESSION ANXIETY

GENITOURINARY:

BURNING ON URINATION BLOOD IN URINE KIDNEY STONES ENLARGED PROSTATE

GYNECOLOGIC (IF APPLICABLE):

ABNORMAL BLEEDING PELVIC PAIN

LAST MENSTRUAL CYCLE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_HOW MANY PREGNANCIES?\_\_\_\_\_\_\_\_\_CHILDREN\_\_\_\_\_\_\_\_\_\_\_

LAST MAMMOGRAM\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_LAST PAP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ARE YOU PREGNANT OR PLANNING TO BECOME PREGNANT: YES NO

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

*OFFICE USE ONLY:*

FORM REVIEWED BY:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_