

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

**In your own words, briefly describe the problem that brings you here:**

**How long have you had this problem? (months, years) \_\_\_\_\_**

**Symptoms occur (circle all that apply):**

seasonal    spring    summer    fall    winter    every day    all year    intermittent

**I am here for the following medical problems (circle all that apply):**

cough    wheeze    headache    nasal stuffiness    nasal drainage    sinus infections  
asthma    bronchitis    chest tightness    short of breath    hives    eczema    dry skin  
itchy skin    sneezing    watery eyes    itchy eyes    ear infections    swellings  
upper resp infections    pneumonia    swelling of eyes    stomach pain  
food allergy    diarrhea    insect sting allergy    drug allergy    snoring    migraine  
fatigue    post nasal drip    sinus headaches    skin rashes    hay fever    sinusitis

Other: \_\_\_\_\_

**Please circle all the things that may trigger symptoms:**

smoke    aerosols    paint    fumes    dust    odors    cut grass    plants    soap  
hot temperature    cold air    rain    humidity    wind    weather changes  
exercise    infections    colds    excitement    stress    dog    cat    laughter  
mold    pollen    leaves    cosmetics    dampness    hay

Other: \_\_\_\_\_

**Are you allergic to any medications? If so, please list the medication and a brief summary of the type of reaction:**

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

**Are there any foods that you suspect you are allergic to?**

List the food and a brief description of the type of reaction:

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

**Have you had any hospitalizations or surgery?**

List year, hospital, reason for stay and physician:

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

**Please turn this page over and complete the back**

**Do you have any of the following? Please check (X) your answers and write any explanation in "comments".**

	Yes (now)	Yes (past)	comments
Ear, nose, throat trouble or nasal polyps			
Hearing loss, loss of taste, loss of smell,			
Chronic or frequent colds			
Sinus or frequent sinus infections			
Hayfever (sneezing, watery eyes, itchy nose)			
Asthma or asthmatic bronchitis			
Pneumonia			
Shortness of breath or wheezing			
Pain or pressure in chest			
Chronic cough or bronchitis			
Skin disease, hives, ecsema, psoriasis			
Swelling of eyelids, lips or body			
Frequent or severe headaches or migraine			
Eye trouble, including cataracts, glaucoma			
Swollen or painful joints or arthritis			
AIDS or HIV positive			
Tuberculosis			
Heart disease (angina, heart failure)			
Frequent indigestion or ulcer disease			
Stomach, liver or intestinal trouble			
Urinary or bladder trouble			
Blood transfusion			
Tumor, growth, cancer			
Recreational drug use (marijuana, cocaine, etc.)			
I may have a drinking problem			
High or low blood pressure			
Diabetes or Thyroid disease			
Bee sting allergy			
Unusual stress at home or work			
Dizziness			
Nervous trouble, irritability, anxiety			
Depression			
Fatigue, extreme tiredness			
Inability to concentrate or loss of memory			
Recent loss of weight			

**Patient Name** \_\_\_\_\_ **Date** \_\_\_\_\_

**Family History** (known medical problems such as allergies, asthma, hay fever, heart disease, high blood pressure, sinus, headaches, etc. Note if alive or not, current age, or age of death and cause of death):

Mother: \_\_\_\_\_

Father: \_\_\_\_\_

Brother/Sister 1: \_\_\_\_\_

Brother/Sister 2: \_\_\_\_\_

Brother/Sister 3: \_\_\_\_\_

Child 1: \_\_\_\_\_

Child 2: \_\_\_\_\_

Child 3: \_\_\_\_\_

**At Home:**

About how old is your house/apartment? \_\_\_\_\_

How long have you lived in your house/apartment? \_\_\_\_\_

Is your house in a residential, country, or farm area? (circle)

Are there open fields less than 1/2 mile from your house? yes / no

Is there water nearby the house like a lake, stream, or pond? yes / no

What type of heating system do you have? gas, forced air, oil, electric,  
wood, other \_\_\_\_\_ (circle)

Do you have airconditioning? yes / no Window unit or central? (circle)

Do you have an attic fan? yes / no

Do you have a humidifier, either portable or attached to the furnace? yes / no

Is the basement in your house dry or damp? (circle)

Do you use a vaporizer? yes / no

Do you have an air cleaner? yes / no Portable or central? (circle)

Do you have any plants in the house? yes / no number \_\_\_\_\_

How many people smoke at home? \_\_\_\_\_

Is there smoking inside the house? yes / no

Are you (the patient) a smoker? yes / no

How many years have you smoked? \_\_\_\_\_

How many packs of cigarettes do you smoke each day? \_\_\_\_\_

Do you have any pets? yes / no cat \_\_\_\_\_ dog \_\_\_\_\_ birds \_\_\_\_\_ other \_\_\_\_\_

Are the pets ever inside the house? yes / no

Do the pets come inside the bedroom? yes / no

**Bedroom:**

What kinds of pillows are in the bedroom? feather, Dacron, foam, unknown  
(circle)

Do you have a down quilt in the bedroom? yes / no

Are the floors in the bedroom carpeted? yes / no

**Misc:**

Is there any obvious mold growth/ odors: home work school (circle)

Is there any obvious water damage or flooding: home work school (circle)

Is your home: dry average damp (circle)

Are there hobbies or work at home that use materials or chemicals that you might inhale or come in contact with? Please list and give details.

---

---

What do you like to do with your free time? (sports, hobbies, church work, choir, reading, gardening, crafts, etc)

---

---

**Work:** (Skip this section if the patient is a child.)

What type of work do you do? \_\_\_\_\_

---

Are there smokers at work? yes / no

Do you have exposure with any fumes or chemicals at work? yes / no

List those that you know or suspect. \_\_\_\_\_

---

Is there adequate air ventilation at your work? yes / no

**Is there anything else you would like me to know about?**

**Are there any questions you might want to ask?**

Thank you for filling out this form.