

# Allergy & Asthma

of Southern Indiana, P.C.

Today's Date \_\_\_/\_\_\_/\_\_\_

Name \_\_\_\_\_

Age \_\_\_\_\_

Birth Date \_\_\_/\_\_\_/\_\_\_

How did you hear about us? Newspaper Bulletin Yellow Pages Calendar

Friend Hospital Other \_\_\_\_\_

Referring Physician \_\_\_\_\_

Family Physician \_\_\_\_\_

Chief complaint. Why are you here?

Length of symptoms? \_\_\_\_\_

## Symptoms - Circle any symptoms you have had:

### HEAD AND NECK

Eyes: itchy	watery	red
Ears: itchy	popping	plugged
Nose: itchy/rubbing	sneezing fits	runny - clear/white yellow green
stuffy/congested	snoring	mouth breathing
↓ or loss of smell/taste	frequent nosebleeds	dripping back of throat
Headaches: frontal	maxillary (cheekbones)	migraines

### LUNGS

Shortness of breath \_\_\_ times/day, ? with exertion?  
 Wake from sleep short of breath \_\_\_ times/week  
 Difficulty breathing wheezing chest tightness  
 Cough: at night? with exercise?  
 sputum? clear/white yellow green

### ASTHMA

Diagnosed at age \_\_\_\_\_  
 Last hospitalized \_\_\_\_\_ Ever intubated? Yes No  
 Proventil/ventolin use \_\_\_\_\_ times/day  
 During past year: \_\_\_\_\_ # courses prednisone  
 \_\_\_\_\_ # ER visits

Any CXR's?/CT sinus? - (when?)

Number of Infections past yr: Sinuses \_\_\_ Ears \_\_\_  
 Bronchitis \_\_\_ Pneumonia \_\_\_  
 No. of Antibiotics past yr. \_\_\_

### SKIN

Hives/Urticaria Edema Itching Eczema

Are Hives associated with: Pressure from garments/belts/straps  
 (circle) Insect bites infections  
 Exercise contact with water  
 Wind or strong breezes  
 Scratching/stroking skin  
 Family history of hives/edema

Foods \_\_\_\_\_  
 Medicines \_\_\_\_\_  
 Cold temperatures or contact with cold items  
 Vibrations (mixers, jack hammer, other)  
 Exposure to the sun/artificial light  
 Swelling/Edema alone, without hives

### STOMACH/INTESTINES

Indigestion/heartburn  
Abdominal pain  
Ulcers/gastritis

### NEUROLOGIC/PSYCHIATRIC

Convulsions/seizures  
Nervous or anxiety disorder  
Depression

### CARDIAC

Heart attacks  
Heart failure

### ENDOCRINE

Thyroid disease  
Diabetes

### MUSCULOSKELETAL

Arthritis  
Muscle weakness

### BLOOD/LYMPH

Anemia  
Swollen lymph nodes

### KIDNEYS/BLADDER

Frequent infections  
Stones

### OTHER

High blood pressure  
Fatigue Weight loss  
Fever/chills 8/9/02

Name \_\_\_\_\_

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DOB \_\_\_\_\_

Date \_\_\_\_\_

Circle if your symptoms are worse when exposed to:

Dust	Feathers	Dogs, Cats, other animals
Pollen	Grass cuttings	
Damp basements	Fallen leaves	Hay/Barnyards
Fumes	Smoke	Hair Sprays/Colognes

Circle times when symptoms are present:

Circle seasons when symptoms worsen:

Year Round    Spring    Summer    Fall    Winter

Spring    Summer    Fall    Winter

Circle the factors that aggravate your symptoms:

Heat	Cold	Humidity	Weather changes
Exercise	Fatigue	Infections	

ENVIRONMENT

Type of home:    House    Mobile home    Apartment    Age of home \_\_\_\_\_ years old

How long have you lived there? \_\_\_\_\_

Where did you live before? \_\_\_\_\_

Do you have: (circle)	wall to wall carpet	area rugs	hardwood floors
	indoor plants	cloth furniture	mildew in any rooms
	basement:	dry    damp	mildew/moldy smell
	crawl space under house		
Bed:	mattress	water bed	futon    Feather: comforter/quilt
Pillows:	synthetic	feather	
Heating:	gas	electric	heat pump    wood stove    Other _____
Air conditioning:	none	central	window units

Do you humidify your home?    Yes    No    Winter only    Lake or pond near home:    Yes    No

List animals: In the home \_\_\_\_\_    Outside the home \_\_\_\_\_

**Social History:**

Birth: full term/ \_\_\_ weeks    Breast until \_\_\_ months    Bottle begun \_\_\_ months    Solid food begun \_\_\_ months

Growth & Development:    normal    abnormal    Immunizations: Up to date    Late    Attends daycare: Yes    No

Occupation \_\_\_\_\_    Days of work/school missed per year \_\_\_\_\_

Smoke: \_\_\_ Never    \_\_\_ pks/day x \_\_\_ yrs    Quit: \_\_\_ yrs ago    Other family members smoke?    Yes    No

<b>Family allergies:</b> (check)	<u>Asthma</u>	<u>Hay Fever</u>	<u>Eczema</u>	<u>Sinusitis</u>	<u>Ear Infections</u>
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brothers	_____	_____	_____	_____	_____
Sisters	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____

Hereditary diseases: \_\_\_\_\_

Name \_\_\_\_\_

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DOB \_\_\_\_\_

Date \_\_\_\_\_

**Describe allergies to:** Medications: \_\_\_\_\_

\_\_\_\_\_

Insect Stings: \_\_\_\_\_

\_\_\_\_\_

Foods: \_\_\_\_\_

\_\_\_\_\_

**PREVIOUS THERAPY**

	Improved	Not Improved	Side Effects
<u>Antihistamines</u>	_____	_____	_____

<u>Decongestants/cold meds</u>	_____	_____	_____
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<u>Nose sprays/drops (list)</u>	_____	_____	_____
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_____	_____	_____	_____
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<u>Asthma medicines (list)</u>	_____	_____	_____
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<u>Inhalers</u>	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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_____	_____	_____	_____
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<u>Prednisone/Medrol</u>	_____	_____	_____
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<u>Other</u>	_____	_____	_____
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<u>Accolate Singulair</u>	_____	_____	_____
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_____	_____	_____	_____
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**Current Medications**  
(Include "over the counter" medicines)

PREVIOUS ALLERGY EVALUATION: Yes No

Have you ever had skin tests or allergy blood tests (RAST)? Yes No

When? \_\_\_\_\_ Doctor \_\_\_\_\_

Results of tests:

Have you ever been on allergy shots? Yes No Dates: \_\_\_\_\_ to \_\_\_\_\_ Did they help? Yes No

If shots were stopped, why were they stopped?

**PAST MEDICAL HISTORY**

Serious illnesses: \_\_\_\_\_

\_\_\_\_\_

Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

Operations: \_\_\_\_\_

\_\_\_\_\_