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PATIENT HISTORY:

Name ______________________________ Date of Birth ______________

Today's Date _____________

What are the symptom(s) that bother(s) you the most?

ALLERGY HISTORY:

Have you been diagnosed with allergies? ☐ Yes ☐ No

Do you experience runny nose, congestion, and sneezing? ☐ Yes ☐ No

Do you have itchy, watery eyes? ☐ Yes ☐ No

When are your symptoms present? ☐ Spring ☐ Fall ☐ Year-round ☐ Around animals /dust / pollen

Do you have history of sinus infections? ☐ Yes ☐ No

Do you have history of ear infections? ☐ Yes ☐ No

Have you had allergy testing before? ☐ Yes ☐ No

If yes, what type of testing was it? ☐ Skin testing ☐ Lab testing

Have you ever had a sinus CT scan? ☐ Yes ☐ No

Have you ever been to a ear, nose and throat specialist? ☐ Yes ☐ No

Have you ever had surgeries for sinus, ear tubes, adenoids, or tonsils? ☐ Yes ☐ No

What medications have you tried for you symptoms?

☐ Benadryl ☐ Claritin ☐ Zyrtec ☐ Allegra

LOWER RESPIRATORY HISTORY

Do you have a history of asthma? ☐ Yes ☐ No

Do you have cough, shortness of breath? ☐ Yes ☐ No

If Yes, with activity or at nighttime?

Do your symptoms get worse with the following?

☐ Illness ☐ Exercise ☐ Cold air ☐ Lying down

Have you ever had pneumonia ? ☐ Yes ☐ No

Have you ever had bronchitis? ☐ Yes ☐ No

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Have you ever had a CXR or a Chest CT? ☐ Yes ☐ No

What medications have you used for the above symptoms?

☐ Albuterol ☐ Advair ☐ Flovent ☐ QVAR ☐ Asmanex ☐ Symbicort?

SKIN HISTORY

Do you have history of eczema or hives? ☐ Yes ☐ No

Do you have symptoms of itchy, red or scaling skin? ☐ Yes ☐No

If yes, do the following make your symptoms worse?

☐ Animals ☐ Winter season ☐ Illness ☐ Symptoms present year-round

Have you had the following skin infections? ☐ Cellulitis ☐Impetigo

What medications have you tried?

☐ Elidel ☐ Acclovate ☐Triamcinolone (topical steriod) ☐ Daily moisturizer (lotion)

ADDITIONAL ALLERGY HISTORY

Do you have any allergies to bee or insect stings/bites? ☐ Yes ☐ No

Do you have any allergy or sensitivity to latex? ☐ Yes ☐ No

Do you have any allergy or sensitivity to any medications? ☐ Yes ☐ No

If yes, ____

FOOD ALLERGY HISTORY

Do you have a history of food allergies? ☐ Yes ☐No

Food/Reaction: ____

____

____

____

Do you experience itching around or in mouth, hives or vomiting? ☐ Yes ☐ No

Have you had an epipen prescribed? ☐ Yes ☐ No

What foods have you tried to eliminate from your diet?

Did your elimination diet help? ☐ Yes ☐ No

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GASTROINTESTINAL HISTORY

Do you have a history of Gastrointestinal Disorders? ☐ Yes ☐ No

☐ Irritable Bowel Syndrome ☐ Crohn's Disease ☐ Ulcerative Colitis ☐ GERD ☐ Lactose intolerance

Do you have recurrent diarrhea, constipation, abdominal pain? ☐ Yes ☐ No

Do you have any difficulty swallowing? ☐ Yes ☐ No

Do you have a history of GI infections? ☐ Yes ☐ No

Do you have a history of Giardia Infection? ☐ Yes ☐ No

What medications have you tried?

What testing have you had performed? ☐ UpperGI ☐ Endoscopy ☐ Colonoscopy

Have you seen a GI specialist? ☐ Yes ☐ No

IMMUNE HISTORY

Vaccine History (Add year if known)

DPT (Diptheria Pertussis Tetanus) - Year(s) ________

MMR (Measles Mumps Rubella) - Year(s) ________

Hepatitis A - Year(s) ________

Hepatitis B - Year(s) ________

Hib (Hemophilus Influenza Type B) - Year(s) ________

MPSV4 (Menactra®) - Year(s) ________

PPV - Year(s) ________

HPV (Human Papilloma Virus, Gardisil®) - Year(s) ________

Influenza Vaccine - Most RecentYear(s) ________

Pneumococcus Vaccine (Pneumovax®, Prevnar®) - Year(s) ________

Infection History

Varicella (Chickenpox, Shingles) - Year(s) ________

Infectious Mononucleosis (Epstein-Barr Virus EBV) - Year(s) ________

Pertussis (Whooping Cough) - Year(s) ________

Ear Infections - _____ times per year

Sinus Infections - _____ times per year

Lung Infections (Pneumonia) - _____ times per year

Bronchitis - _____ times per year

Strep Throat Infections - _____ times per year

Skin Infections - _____ times per year

(Continued on next page)

Urinary Tract Infections - _____ times per year

Upper Respiratory Viral Infections (Common Cold) - _____ times per year

Gastrointestinal Viral Infections (stomach viruses) - _____ times per year

Cold Sores (Herpes Simplex Virus Type 1) - _____ times per year

Yeast Infections - _____ times per year

Other Infections (Such as Tuberculosis, Traveler's Diarrhea, Giardia, Typhoid etc..) ______________________________

Average number of antibiotic courses per year: ______________________________

Antibiotics that usually work: ______________________________

Antibiotics that usually do not work: ______________________________

Allergies to antibiotics (what reaction): ______________________________

Any other comments: ______________________________

____

____

PAST MEDICAL HISTORY

Prior surgeries: ______________________________

Hospitalization or emergency room visits:______________________________

Do you have a history of immune disorders? ☐ Yes ☐ No

Do you have a history of autoimmune disorders? ☐ Yes ☐ No

Do you have a history of thyroid disorders? ☐ Yes ☐ No

Do you have a history of neuro/developmental disorders ☐ Yes ☐ No

FAMILY HISTORY

Is there a history of allergies, asthma, immune or autoimmune disorders in your family? ☐ Yes ☐ No

Please Describe: ______________________________

SOCIAL HISTORY

What is your occupation? ______________________________

What type of environment do you work in? ______________________________

Is your work affected by your symptoms? ☐ Yes ☐ No

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ENVIRONMENTAL HISTORY

Location: ☐ city ☐ suburb ☐ country/farm **Structure:** ☐ house ☐ apartment

Age of building: _________ **Number of years at this address** ______

Recent painting or repairs: ____

Basement: ☐ slab ☐ finished ☐ dry ☐ damp mildew

Flooring: ☐ hardwood ☐ carpet ☐ (wool / synthetic)

Furniture: ☐ new ☐ antique

Treatments: ☐ drapes ☐ blinds ☐ shades

Heating System: ☐ hot air ☐ hot water ☐ electric baseboard

Fuel: ☐ gas ☐ electric ☐ coal ☐ oil

Air Filters: ☐ fiberglass ☐ electrostatic ☐ HEPA

Air Conditioning: ☐ central ☐ window unit ☐ humidifier ☐ dehumidifier

Bedroom Windows Open: ☐ day ☐ night ☐ winter ☐ summer

Bedding/Covers: ☐ cotton ☐ synthetic ☐ feathers ☐ allergy covers

Pillows: ☐ feather ☐ synthetic

Pets: ☐ cat ☐ dog ☐ bird ☐ other

Infestation: ☐ cockroaches ☐ mice ☐ rats

Smoking: ☐ patient ☐ family member ☐ co-workers ☐ other