Allergy & Asthma Care Center
Breathe Better · Live Better!

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Allergy &Asthma Care Center, PA

New Patient History

Complete the following information. Please put an X in each box that relates to your problems. Use additional page to answer any questions if more room is needed.

Patient Name: _____ Date of Birth _____ Date of First Visit: _____
(Please Print)

Were you referred by a physician or other provider? ☐ no ☐ yes If yes, who _____

Briefly state what problems are bringing you here: _____

Upper Respiratory Tract (Nose, Sinus, Ear, and Eye) Problems

Note: If No UPPER Respiratory Tract problems, Check Here ☐ And Go To Page 2 - Lower Respiratory Tract.

When did these symptoms first begin? _____

☐ sneezing ☐ itching nose ☐ runny nose
☐ nasal congestion ☐ stuffiness ☐ post-nasal drip
☐ decreased or absent sense of smell
☐ nose bleeds ☐ snoring
☐ nasal polyps; if so: ☐ past ☐ present
☐ drainage cough ☐ sore throat
☐ itchy throat ☐ bad breath
☐ frequent colds; if so, how many per year? 1-5 ☐ 5-10 ☐ ☐
headaches/sinus pain _____ ☐
recurrent ear infections ☐ ear plugging / popping / fullness ☐
hearing loss ☐ dizziness
☐ septum deviated ☐ septum perforated

☐ previous nasal or sinus surgery
☐ recurrent or chronic sinus infections; if so, how many per year?
☐ 0-4 ☐ over 4
☐ sinus x-rays or sinus CT scan done
- if so, when? _____
- result ☐ normal ☐ abnormal

☐ ENT evaluation; if so, when? _____
- name of doctor: _____

Eyes: ☐ itch ☐ red ☐ watering ☐ swollen lids
☐ dark circles ☐ fatigue / tired ☐ poor concentration
☐ other: _____

Symptoms Caused Or Aggravated By:

☐ cold air ☐ weather
☐ odors / scents / fragrance ☐ tobacco smoke
☐ dusting / vacuuming ☐ musty odors / mold
☐ yard work / pollens ☐ being outdoors
☐ aspirin / related medications
☐ animals, list: _____
☐ other: _____

Year-round symptoms? ☐ yes ☐ no

Season(s) in which symptoms are **worst**: ("X" all that apply)
☐ spring ☐ summer ☐ fall ☐ winter

Symptoms worse: ☐ AM ☐ PM ☐ night

Symptoms interfere with: ☐ sleep ☐ exercise / activity
☐ missed school ☐ missed work

Symptoms are: ☐ improving ☐ worsening ☐ unchanged

List medications tried for **nose/sinus** symptoms (include prescription and over-the-counter oral medications and nasal sprays):

Current Medication	Does it work?	Past Medication	Did it work?
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no

Office Use Only: _____

Name_____

Lower Respiratory Tract (Chest, Lung) Problems

Note: If No LOWER Respiratory Tract Problems, Check Here ☐ And Go To Page 3.

When did chest symptoms first begin? _____

☐ chronic or recurrent cough ☐ coughing spells

☐ dry ☐ loose; is mucus coughed up? ☐ yes ☐ no

- if yes, is mucus colored? _____

☐ coughing up blood

☐ wheezing; when breathing ☐ out ☐ in

☐ chest tightness or pressure ☐ throat tightness

☐ shortness of breath ☐ difficulty taking a full breath

☐ cough or breathing problems interfer with sleep

☐ asthma diagnosed by a physician? Age:_____

☐ Emergency room visit(s) for asthma; how many?_____

☐ Hospitalized for asthma; how many?_____

☐ Intensive care unit for asthma

☐ oral steroids (Prednisone, Medrol, Prednisolone) taken for asthma

- if so, number of times taken per year:

  ☐ 1 ☐ 2 - 3 ☐ greater than 3

- date of last use: _____

☐ history of recurrent bronchitis

☐ history of recurrent pneumonia

☐ history of recurrent croup

☐ previous chest x-ray or chest CT scan; if so, when?_____

- result: ☐ normal ☐ abnormal

☐ peak flow meter used; if so, best reading:_____

☐ pulmonary function (lung) test: ☐ yes ☐ no

☐ pulmonary (lung specialist) evaluation; when: _____

- specialist's name: _____

☐ Are you physically active on a regular basis (formal exercise, play sports, other types of physical activity)? ☐ yes ☐ no

☐ Do you experience a cough, wheeze, difficulty breathing during exercise/physical activity? ☐ yes ☐ no

☐ other symptoms (list): _____

Symptoms Caused Or Aggravated By:

☐ colds / upper respiratory infections ☐ sinus infections ☐ exertion / exercise; type:_____

☐ cold air ☐ weather change

☐ odors / scents / fragrance ☐ tobacco smoke

☐ eating / drinking ☐ heartburn / acid reflux

☐ emotional stress / anger ☐ laughing / crying / cough

☐ your workplace or school ☐ aspirin / related medications

☐ dusting / vacuuming ☐ musty odors / mold

☐ yard work / pollens ☐ being outdoors

☐ animals, list:_____

☐ other:_____

Year-round symptoms? ☐ yes ☐ no

Season(s) in which symptoms are **worst**: ("X" all that apply)

☐ spring ☐ summer ☐ fall ☐ winter

Symptoms interfere with: ☐ sleep ☐ exercise / activity ☐ missed school ☐ missed work

Symptoms are: ☐ improving ☐ worsening ☐ unchanged

List medications tried for **lower respiratory** symptoms (include prescription and over-the-counter oral, inhaled, and injected medications):

Albuterol ☐ inhaler ☐ nebulizer How often used?_____

Current Medication	Does it work?	Past Medication	Did it work?
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no

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Name:_____

Skin Problems

Note: If No SKIN Problems, Check Here ☐ And Go To 'Previous Allergy Evaluation' below.

Skin Symptoms:

☐ eczema ☐ rash

When did skin/eczema symptoms first begin? _____

☐ itching ☐ excessively dry, scaly skin

☐ irritated red patches ☐ weepy, oozing rash

☐ recurrent skin infections

☐ welts /hives ☐ skin swelling

When did hives/swelling first begin?

☐ itching ☐ face swelling ☐ hand /foot swelling

☐ lip swelling ☐ tongue /throat swelling

☐ difficulty breathing from swelling

☐ other skin symptoms (list):_____

Location of eczema/rash/hives: ☐ arms ☐ legs ☐ trunk ☐ head ☐ neck

Frequency of above symptoms: ☐ daily ____times per week ____times per month ☐ other:_____

Do skin symptoms occur year-round? ☐ yes ☐ no

Season(s) in which above skin symptoms are worst: ☐ spring ☐ summer ☐ fall ☐ winter

Has a physician diagnosed your rash? ☐ yes ☐ no

- if yes, what was the diagnosis? ☐ hives ☐ eczema ☐ contact dermatitis ☐ other:_____

Have you seen a dermatologist for your skin problems? ☐ yes ☐ no

- if yes, name of doctor:_____ when seen:_____

List everything that causes or aggravates your skin symptoms:

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

List medications tried for **above** symptoms (include prescription and over-the-counter oral medications, creams, and ointments):

Current Medication	Does it work?	Past Medication	Did it work?
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no
_____	☐ yes ☐ no	_____	☐ yes ☐ no

Previous Allergy Evaluation(s): ☐ no ☐ yes Date(s):_____

Skin testing: ☐ no ☐ yes Blood testing for allergy: ☐ no ☐ yes Were you allergic? ☐ no ☐ yes

- if allergic, was it to: ☐ animals ☐ dust /mites ☐ pollen ☐ mold ☐ food ☐ other (list):_____

Allergist: Name: _____ State:_____

Previous allergy injection(s): ☐ no ☐ yes If yes, age or date(s) of treatment: _____

If yes, how long did you take shots? ☐ 6 month ☐ 1 year ☐ 2 years ☐ 3 years ☐ longer

- were allergy injections effective? ☐ no ☐ yes ☐ not sure
- adverse reactions to allergy injection(s)? ☐ no ☐ yes If yes, list:_____

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_____

_____

_____

_____

_____

Name:_____

Insect Sting Reactions: ☐ no ☐ yes If yes, insect(s) causing reaction: _____

- symptoms: ☐ large swelling at site ☐ hives ☐ breathing problems ☐ dizzy/lightheaded
  ☐ other (list): _____
- age or date when occured?_____ (Epi-Pen) Epinephrine/Adrenalin device prescribed? ☐ no ☐ yes

Drug Allergies / Intolerances: ☐ no ☐ yes

Name Or Type Of Medication	Reaction(s) Noted	When Did Reaction Occur? Age or Date	Is The Medication Completely Avoided?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Food Allergies / Intolerances: ☐ no ☐ yes

Food	Reaction(s) Noted	When Did Reaction Occur? Age or Date	Is The Food Completely Avoided?
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no
			☐ yes ☐ no

Latex or Rubber Allergies / Intolerances: ☐ no ☐ yes
If yes, explain: _____

Past Medical History:

Flu vaccine: ☐ no ☐ yes Pneumonia vaccine: ☐ no ☐ yes T.B. test: ☐ no ☐ yes result: ☐ positive ☐ negative

Birth history (if patient is a child): ☐ normal ☐ premature ☐ problems at birth: _____

Hospitalization(s): ☐ none _____

Surgery(s): ☐ none _____

Serious injury(s): ☐ none _____

Other medical problems: _____

All Current Medications not already listed (Include Over-The-Counter and Supplements. Use additional page if necessary.)

Medication	Dosage	Frequency (how often)	Medication	Dosage	Frequency (how often)

Family History:

Do any close family members have the following? **Check the appropriate box below:** (even if mild or outgrown)

	Father	Mother	Brothers	Sisters	Children
Hay fever / Allergies	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐
Sinus trouble	☐	☐	☐	☐	☐
Migraine headache	☐	☐	☐	☐	☐

Other diseases that run in the family:

Immune problems ☐ yes ☐ no
Family member: _____

Cystic Fibrosis ☐ yes ☐ no
Family member: _____

Emphysema ☐ yes ☐ no
Family member: _____

Name: _____

Social History:

Has the patient ever smoked? ☐ no ☐ yes If yes, for how many years: _____

Current smoker? ☐ yes ☐ no If no, when did you quit: _____

- how much do/did patient smoke? Number of packs per day ☐ less than 1/2 ☐ 1/2 ☐ 1 ☐ 2 or more Alcoholic beverages? ☐ no ☐ yes If yes, how often: _____

Marijuana or other "recreational" drugs? ☐ no ☐ yes If yes, how often: _____

Review of Systems: (check all that applies)

General

- ☐ Good general health
- ☐ Weight gain; past year: _____lbs.
- ☐ Weight loss: _____lbs.
  - dieting ☐ yes ☐ no
- ☐ Excessive tiredness
- ☐ Excessive thirst/drinking
- ☐ Recurrent fever
- ☐ Recurrent night sweats
- ☐ Pregnant
- ☐ Planning pregnancy within year
- ☐ Cancer history
  - type: _____

Eyes ☐ Does not apply

- ☐ Dry eyes
- ☐ Wear contact lenses
- ☐ Cataracts
- ☐ Glaucoma

Mouth/Throat ☐ Does not apply

- ☐ Excess dryness of mouth
- ☐ Excessive throat mucus*
- ☐ Throat clearing*
- ☐ Hoarseness or voice problems*
- ☐ Sensation of something stuck in throat*

Heart ☐ Does not apply

- ☐ Palpitation or pounding of heart
- ☐ Irregular heart beat
- ☐ Angina/chest pain/tightness
- ☐ History of heart attack
- ☐ Thrombophlebitis/blood clots
- ☐ Swollen ankles/feet
- ☐ Heart murmurs
- ☐ High blood pressure

Gastrointestinal ☐ Does not apply

- ☐ Difficulty swallowing*
- ☐ Heartburn/acid indigestion/reflux
  - stomach acid coming up*
  - frequency: _____
  - treatment: _____
- ☐ History of ulcer
- ☐ Frequent spitting up or wet burps (infants)
- ☐ Hiatal hernia
- ☐ Recurrent vomiting
- ☐ Frequent diarrhea
- ☐ Bloody or black stools
- ☐ Constipation
- ☐ Liver disease: _____
- ☐ History of Hepatitis
  - Hepatitis Type: ☐A ☐B ☐C
  - if so, when diagnosed _____
- ☐ Other problems: _____

_____

- ☐ GI specialist: _____
  - when: _____

Genitourinary ☐ Does not apply

- ☐ Frequent urination
- ☐ Kidney trouble
- ☐ Bladder infection
- ☐ Prostate problem (men)
- ☐ Kidney stones

Musculoskeletal ☐ Does not apply

- ☐ Painful or stiff joints
- ☐ Swollen joints
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis (age/injury related)
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Bone Density Test
  - date: _____

Endocrine ☐ Does not apply

- ☐ Thyroid gland problems
- ☐ Adrenal gland problems
- ☐ Diabetes
- ☐ Parathyroid disease

Neurologic ☐ Does not apply

- ☐ Sinus headache
- ☐ Migraine headache
- ☐ Tension headache
- ☐ Hyperactivity/ADD/ADHD
- ☐ Dizzy spells
- ☐ Fainting spells
- ☐ Convulsions/epilepsy/seizures
- ☐ Sleep Apnea
- ☐ Insomnia ☐

Depression ☐

Anxiety

- ☐ Ever see a psychiatrist/psychologist?
  - ☐ Currently see one

Blood/Lymphatic ☐ Does not apply

- ☐ Blood disorder:
- ☐ Anemia
- ☐ Bruise easily
- ☐ Swollen lymph nodes _____
- ☐ Previous blood transfusion
- ☐ Risk factors for AIDS
- ☐ Testing for HIV
  - if so, result: ☐ positive ☐ negative

☐ **Other symptoms or medical problems** (list)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

ROS reviewed with patient/parent

MD/PA Initials_____

Name:_____

Environmental History

How long has patient lived in New Jersey?_____ What other states/countries has patient lived in? _____

Primary Home (for patient living in two homes, also complete "Second Home" below)

Type: ☐ house ☐ townhouse ☐ condominium ☐ apartment ☐ mobile home ☐ other: _____

Age of home: ☐ less than 10 years ☐ 10-20 years ☐ 20-50 years ☐ over 50 years Length of time in home:_____

Construction

Basement: ☐ none ☐ finished ☐ unfinished ☐ walkout ☐ dirt ☐ crawl space ☐ moisture problem

Heating and Cooling

Heat: ☐ forced air heat ☐ hot water or radiant heat ☐ electric heat ☐ woodburning stove ☐ Fireplace; ☐ wood ☐ gas

Cooling system: ☐ none ☐ central air ☐ window air conditioner ☐ swamp cooler ☐ attic fan

Central filter type: ☐ none ☐ fiberglass ☐ HEPA ☐ electrostatic Frequency of filter change or cleaning: _____

Room air filter: ☐ none ☐ HEPA ☐ electrostatic ☐ ion generator ☐ other:_____ • which room_____

Air Ducts cleaned: ☐ no ☐ yes If yes, when_____

Mold and Moisture

Humidifier: ☐ none ☐ furnace ☐ cold-mist ☐ ultrasonic ☐ steam

Water leak(s): ☐ none ☐ past ☐ current ☐ musty odor ☐ visible mold

Cleaning

Frequency of dusting: ☐ daily ☐ 2-3 times per week ☐ 1 time per week ☐ every 2 weeks ☐ less often

Frequency of vacuuming: ☐ daily ☐ 2-3 times per week ☐ 1 time per week ☐ every 2 weeks ☐ less often

Patient's Bedroom

Flooring: ☐ carpet ☐ wood ☐ tile ☐ linoleum ☐ area rug

Bed: Mattress: ☐ innerspring ☐ foam ☐ waterbed ☐ bunk ☐ futon

Pillow: ☐ feather (down) ☐ foam ☐ synthetic

Pets

☐ no ☐ yes

	Number	How Long Owned?	Type/Breed	Outside	Inside	Sleep in Bedroom
☐ Dog(s)	_____	_____	_____	☐	☐	☐
☐ Cat(s)	_____	_____	_____	☐	☐	☐
☐ Other(s)	_____	_____	_____	☐	☐	☐

Smokers (at your home)

☐ No one ☐ patient ☐ mother ☐ father ☐ husband ☐ wife ☐ other

Other Environments

Daycare: Number of days per week ☐ Animals Number in room_____

Relatives' Homes: Number of days per week ☐ Animals ☐ Smokers

School/Work: Number of days per week_____ ☐ Animals ☐ Smokers

Hobbies / Interests

_____

Occupation / School / Daycare

Type of work/school/daycare: _____

Kinds of materials exposed to at work/school: _____

Second Home (for patient living in two homes, please complete the following):

Time spent in second home: _____

Smokers:_____

Pets:_____

Other exposures: _____

I have reviewed page 1-6 with parent/patient. _____ Date_____

Physician / PA Signature