Patient Name: ______________________________ **Reviewed by:** _____________________ **Date:** __________

WHAT BRINGS YOU TO OUR OFFICE TODAY?

1.
2.

CURRENT SYMTOPMS:

1. EYES
( ) Watery Eyes
( ) Itching of the eyes
( ) Swelling of the eyelids

2. EAR/NOSE
( ) Sneezing
( ) Runny nose
( ) Blocked nose
( ) Itching/rubbing of the nose
( ) Post-nasal drip
( ) Itching of the ears
1. Past surgery (ear) (nose) (throat)
2. Sense of smell last 6 months
Poor 1 2 3 4 5 6 7 8 9 10 great

4. THROAT/ CHEST
( ) Coughing
( ) Wheezing
( ) Shortness of breath

5. SKIN
( ) Rash
( ) Swelling of the lips
( ) Swelling of the body

6. STOMACH/GI
( ) Nausea/stomach cramps
( ) Diarrhea

7. NEURO
( ) Headache

8. WORSE SEASON
SUMMER / SPRING/ FALL/ WINTER

MEDICAL HISTORY:

1. Birth History/Complications
____
____
____

( ) Ear infections/Sinus infection
( ) Hay fever/Allergy
( ) Allergy skin tests, date: ____
( ) Allergy injections, date: ____
( ) Asthma/croup/ Bronchitis/Pneumonia
( ) Hives/Skin rashes/eczema

How would you describe your diet?

EXELLENT: 5-6 Pieces of fruit/veggies
Low fat, high fiber, low meat
FAIR: 1-2 fruit/veggie/low fat
POOR: Typical Western diet
Fast food, hydrogenated fats

Stress rate in the Last 6 months
Least 1 2 3 4 5 6 7 8 9 10 Most

Have you ever had?

( ) Chicken Pox
( ) Herpes ( ) oral ( ) genital
( ) Problems with vision/hearing
( ) Heart disease/High blood pressure
( ) Diabetes/Thyroid disorder
( ) Liver disease/Hepatitis
( ) Lung infections
( ) Serious infections
( ) Nervous system disorders
( ) Stomach/intestinal disorders
( ) Psychiatric evaluation/medicine
( ) Reaction to foods *
( ) Reaction to medicines *
( ) Reaction to insects stings *

PLEASEDESCRIBE:__________________
____
____
____
____

MEDICATIONS, CURRENT/PAST

(CURRENT)	(PAST)

IMMUNIZATIONS RECEIVED/ UTD

( ) Pneumonia Shot
( ) Varicella/ Chicken Pox
( ) H1N1/ Flu Shot
( ) TB Test ( ) Pos ( ) Neg

FAMILY HISTORY

Do any of your relatives have?

	Hay fever	Asthma	eczema
( ) Mother	( )	( )	( )
( ) Father	( )	( )	( )
( ) Grandparents(s)	( )	( )	( )
( ) Sister(s)	( )	( )	( )
( ) Brother(s)	( )	( )	( )
( ) other relatives	( )	( )	( )

Do any of your relatives have?
( ) Emphysema ( ) Cystic Fibrosis ( ) Lung disease

SOCIAL HISTORY

Job: ________________________
Hobbies: _____________________
Ethnic Origin: _________________
( ) Menopause: last period_______
Air travel/ rare /occasional /often

SMOKING/EXPOSURE

( ) In house/Car/At work
( ) Second Hand Smoke
____
#Cig/Day___ Yrs smoking ___ Last smoked___

Alcohol/drugs

# of drinks/beer/wine per week
____

Caffeinated Beverages

1-2/cups a day # 2-3 #3-4

HOME ENVIROMENT

Locale1) Area/Town/City_________
Approx age of structure__________
Locale 2)
Area/Town/City________________
Approx age of structure_________

	Locale1	Locale2
Central air cond.	( )	( )
Window air cond.	( )	( )
Swamp cooler	( )	( )
Central heating	( )	( )
Fireplace/stove	( )	( )
Flooding/Mold	( )	( )
Humidifier	( )	( )

In your Bedroom, indicate what applies:

Floor:		
Carpet	( )	( )
Wood	( )	( )
Tile	( )	( )
Window covering:		
Curtains	( )	( )
Shades	( )	( )
Mini-blinds	( )	( )
Bed:		
Mattress/Bxspring	( )	( )
Water bed	( )	( )

Other: _______________________

Pillows:		
Feather	( )	( )
Poly	( )	( )
Foam	( )	( )
Stuffed animals	( )	( )
Books	( )	( )
Plants	( )	( )
Pet(s):		
Cat(s) how many	( )	( )
Dog(s) how many	( )	( )
Bird(s) how many	( )	( )

Other________________________
Amount of time the pet(s) is (are):

Indoor % of time	( )	( )
Outdoor % of time	( )	( )
% of time/bedroom	( )	( )