Allergy, Asthma & Sinus Center

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Name:_____ Date:_____ Age:_____ Gender: M/F_____

What is your main concern: _____

Symptoms: Please circle those symptoms that bother you in the chart below:

Eyes	**Nose**	**Ears**	**Sinus**	**Throat**	**Skin**	**Chest**	**Abdomen**	**Reactions/Other**
Itching	Itching	Itching	Headaches	Itching	Itching	Tightness	Acid Reflux/ Heartburn	Cosmetics/ Jewelry
Watering	Sneezing	Fullness	Sinus Pressure	Postnasal Drip	Hives	Coughing	Trouble Swallowing	Foods
Red	Congestion/ Decreased smell	Popping	Sinus Infections	Hoarseness	Eczema	Wheezing	Pain	Insects/Bees
Swelling	Runny	Infections	Discolored drainage	Throat Clearing	Swelling	Shortness of Breath	Nausea/ Vomiting	Latex
Burning	Mouth Breathing, Snoring/ Sleep apnea	Decreased Hearing	Bad breath	Bad or Decreased Taste	Other Rashes	Exercise Induced Trouble Breathing Or Cough	Diarrhea	Aspirin

How long have you had these symptoms: _____# Missed days of school/work due to symptoms: _____

These symptoms occur: (circle all that apply) Spring Summer Fall Winter All of the time

These symptoms are worse when/with: (circle all that apply)

Outdoors	Indoors	Morning	Night	All Day	School	Work	Home	Pets (cat, dog, other)
Cold Air	Humid	Rain	Dust	Pollens	Molds	Change in Temperature		Change in Pressure
Tobacco Smoke		Excercise	Aspirin/Ibuprofen		Food	Odors	Scented candles/perfumes	Other:_____

Allergies	Yes/No	**Healthcare Provider's Notes**:
Any previous allergy testing?		
Any previous allergy shots?		
Reactions to shots: local or general?		
If on shots before, provide dates: _____to _____		
Asthma		
Diagnosis of asthma made: _____years ago		
# of asthma ER visits: per year _____, per lifetime _____		
# of asthma hospitalizations: in lifetime _____		
Dates for last ER visit: _____ last hospital visit:_____		
Do you use a spacer for your inhaler? Yes or No		

Frequent Infections	# per year	# per life
Ear		
Sinus		
Pneumonia		

Previous Imaging of Sinuses or Chest (X ray or CT scan) Date and Results: _____

Name:_____ Date:_____

Home Environment Survey (circle all that apply)

Lives in Basement		Feather Pillow	Forced Air Heat	Fan/Humidifier	Cats (how many)?_____
Plastic Covered Mattress/Pillow		Stuffed Toys	Windows Closed	Change Filters	Dogs (how many)?_____
Down Bedding	Carpet/Rugs	A/C	Cockroaches	Pets in Bedroom	Other Pets? _____
Type of window treatment (circle all that apply) Blinds ◦ Curtains ◦ Shades					
Cigarette smoke: Yes or No. # packs you smoke per day_____ # of years you have smoked? _____					
Quit _____ years ago. Passive smoke exposure at home? Yes or No ◦ Regular Excercise: Yes or No Type _____					
Marijuana: Yes or No					

Social History (circle all that apply)

What environment do you currently live in? House ◦ Town House ◦ Apartment ◦ Trailer ◦ Rural ◦ Urban	Daycare: Yes or No Current school grade:_____
Marital Status: (circle) Married ◦ Single ◦ Divorced ◦ Separated ◦ Widowed ◦ Other	Occupation:_____

Past Medical History **Current Medications**

All Current Medical Conditions (Including those associated with medication listed)	Name	Dose	Frequency

Past Surgeries or Hospitalizations	**Age/Year**

Drug Allergy	**Reaction**

Review of Systems (circle all that apply)

Fatigue	Blurred Vision	Deviated Septum of Nose	Leg Swelling (edema)	Heartburn	Joint Pain
Fever	Cataract	Frequent Sore Throats	High Blood Pressure	Nausea/Vomiting	Anxiety
Dry Skin	Glaucoma	Hoarseness	Irregular Heart Beat	Diarrhea	Behavior Problems
Rashes	Ear Pressure	Metallic Taste	Passing Out	Dizziness	Depression
Dry itchy eyes	Nose Bleeds	Cold/Heat Intolerance	Abdominal Pain	Headache	Other

Family History: Who in your family has these conditions?

Allergies	Hypertension	Hives/Swelling	Cystic Fibrosis	Autoimmune Disease
Sinus Infections	Emphysema/COPD	Thyroid Disease	Eczema	Diabetes
Frequent Infections	Asthma	Heart Disease	Food Allergies	Tuberculosis

Vital Signs (Nurse): WT: _____ HT: _____ T: _____ BP: _____ HR: _____ POX: _____

Physical Exam (Doctor):

HEENT: _____ LUNG: _____

CV: _____ SKIN: _____