



New Patient Medical History

Today's Date: _____

Please state the problem(s) or symptom(s) that bring you here today for consultation:

Which of the following appear to cause your allergy / asthma symptoms?

Animals: Horse Cat Dog Cow Rabbit Other: _____

Odors: Christmas trees Detergents Soaps Tobacco smoke Cosmetics or perfumes Paint fumes

Other: _____

Pollen: Trees Weeds Grasses Molds

Other: Temperature changes Menses(period) Exertion Air Conditioning Infections Excitement
 Windy days Laughing Tension Fatigue Depression Pain relievers (ibuprofen or aspirin)

When did your symptoms begin? (please specify date) _____

When do your symptoms occur? (please circle all that apply) Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Have you ever had an allergic reaction to any medication? Y N

If yes, what specifically happened? _____

Have you ever had an allergic reaction to any food? Y N

If yes, what specifically happened? _____

Have you ever had any insect sting or bite reaction? Y N

If yes, specify date _____ Symptoms: _____

Have you had any Emergency Room visits &/or hospitalizations for allergies or asthma in the past year? Y N

If yes, please describe: _____

FAMILY MEDICAL HISTORY: (please check all that apply)

	Mother	Father	Siblings	Children	Aunts	Uncles	Grandparents
Hay Fever							
Asthma							
Eczema							
Other Lung Disease							

Are there any other conditions that occur in your family (for example, cystic fibrosis, recurrent hives or swelling, or lupus)?

HAVE YOU EVER SEEN AN ALLERGIST PREVIOUSLY? Y N

If yes, who, when and where? _____

Were you diagnosed with allergies? Y N

If yes, what were the findings? _____

Have you ever been on immunotherapy (allergy shots) before? Y N

If yes, when and where? _____ Did it help? Y N

Did you have any severe reactions to the allergy shots? Y N

If yes, please explain: _____

ENVIRONMENTAL / SOCIAL HISTORY

HOME general

Heating: forced air woodstove hot water electric kerosene other _____

Does anyone smoke inside the home? Y N Number of smokers: _____

Flooring in living area: carpeted non-carpeted mixed

Vacuum: regular central HEPA double thickness bags

Basement: none finished unfinished has flooded in past

Portable filter: none HEPA ionizer electrostatic

BEDROOM

Pillow: feather non-feather airtight cover

Mattress: innerspring waterbed other: _____

Comforter: feather non-feather other: _____

Air Conditioning: Y N

Humidifier: Y N

Overhead fan used: Y N

PETS Yes No If Yes, please complete the following:

	Outside	Inside	In bedroom
Cat(s)			
Dog(s)			
Other pets or animals in environment:			

Are there pets at daycare or school? Y N

FOR CHILDREN:

- Attends daycare Y N # of days a week _____ Are there smokers at daycare/school? Y N
 - Immunizations up to date Y N
 - Had Chicken Pox vaccine Y N
 - Lives with both parents in the same home Y N
- If No, are there any smokers in the secondary home? Y N Are there any pets? Y N
- Frequency of visits to secondary home: _____

CURRENT MEDICATIONS

Please list all medications you are using, including any prescription drugs, over-the-counter medications, supplements, vitamins, pain relievers, and any medications taken "as needed." If you need additional space, please list medications on the back of this sheet.

MEDICATION	CURRENT DOSE	START DATE	DATE LAST USED	REASON FOR USE

REVIEW OF SYSTEMS (please check any items that apply)

Constitutional

- good general health
- poor appetite
- recent weight gain or loss
- excessive tiredness
- recurrent fevers (temp = 101°)

Head

- headaches
- migraine headaches
how often? _____
- sinus disease/problems
- head injury

Eyes

- dry eyes
- wear contact lenses
- redness
- itching
- cataracts
- glaucoma

Mouth / Throat

- excess dryness of mouth
- hoarseness
- trouble swallowing
- excessive thirst and drinking
- itching of throat or mouth

Heart

- palpitation or pounding of heart
- angina/chest pain
- irregular heart beat
- heart murmur
- history of heart attack
- high blood pressure

Alcohol History

Average # of drinks/week _____

Other Problems/Illness

Gastrointestinal

- heartburn/acid indigestion
if yes, how often? _____
- wakes you from sleep
- taste heartburn in back of throat
- recurrent vomiting
- frequent diarrhea
- history of ulcer
- hiatal hernia
- history of hepatitis
- history of liver disease

Genitourinary

- kidney trouble
- frequent urination
- prostate trouble/cancer

Musculoskeletal

- painful swelling of joints
- arthritis
- osteoporosis
- scoliosis/curvature of the spine

Ears

- frequent infections
- itching
- blockage
- hearing loss

Neurologic

- hyperactivity disorder/ADHD
- Parkinson's
- depression
- convulsions/epilepsy/seizures
- insomnia
- Multiple Sclerosis
- ever consulted a psychiatrist/psychologist
- mental illness

Blood/Lymphatic

- blood disorder
- anemia
- swollen lymph nodes
- history of
blood product transfusion

Endocrine

- thyroid problems
- diabetes

Skin

- hives
- eczema
- acne
- itchy/dry
- cancer
- psoriasis

Nose

- polyps
- congestion/runny nose
- bleeding
- sneezing
- itching
- loss of smell

If Female

- postmenopausal
- planning pregnancy
when? _____

Smoking History

- never smoked
- former smoker
___ packs a day for ___ years
- current smoker
___ packs a day for ___ years

MY SIGNATURE INDICATES THAT THIS MEDICAL HISTORY IS ACCURATE TO THE BEST OF MY KNOWLEDGE.

PATIENT/GUARDIAN SIGNATURE _____ **DATE** _____