Patient's Name: ____________________ Date of Birth: ____________________ Today's Date: ____________________

Birth weight: Was patient premature? No Yes (*Circle answers where appropriate*)

MEDICAL HISTORY

Allergies	No Yes	Frequent Infections	No Yes
Stuffy runny nose seasonally (hayfever)	No Yes	Boils	No Yes
Stuffy runny nose year round	No Yes	Strep Throat	No Yes
Sneezing	No Yes	Gastrointestinal Problems	No Yes
Itchy, red or watery eyes	No Yes	upset stomach	No Yes
Post-nasal drip	No Yes	belching	No Yes
Anemia	No Yes	heartburn	No Yes
Arthritis	No Yes	constipation or diarrhea	No Yes
Asthma	No Yes	Headaches	No Yes
Bronchitis No Yes	How often? __________	If yes, what type? ______________________	
Pneumonia No Yes	How often? __________	How often? ____________	
Sinusitis No Yes	How often? __________	Heart Disease	No Yes
Ear Infections No Yes	How often? __________	High or Low Blood Pressure	No Yes
Cold Symptoms No Yes	How many/yr?________	Palpitations or Fluttering Heart	No Yes
Cancer	No Yes	Kidney Disease	No Yes
Diabetes	No Yes	bladder urinary	blood in urine
Dizziness	No Yes	Jaundice	No Yes
Enlarged Glands	No Yes	Liver Disease	No Yes
Eczema	No Yes	Neurologic Problems	No Yes
Hives	No Yes	Night Sweats	No Yes
Other Rashes?	No Yes	Thyroid Disease	No Yes
Explain ______________________________		Tuberculosis	No Yes
Medication reactions?	No Yes		

What kind of reaction?____

Which medication caused the reaction?____

Has patient ever been hospitalized? No Yes Reason ________________________________

Has patient ever had surgery? No Yes Reason ________________________________

Does patient ever experience: if yes, how many times per week, month, year?

Wheeze	No Yes	Frequency:
Shortness of breath	No Yes	Frequency:
Cough	No Yes	Frequency:
Chest tightness or pain	No Yes	Frequency:
Symptoms ever awaken patient from sleep?	No Yes	Frequency:
Ever required an Emergency Room visit?	No Yes	Frequency:

Has patient had any x-ray or special tests? No Yes

Type of test:	Date:	Where:	Results:

Was there an Ear, Nose, and Throat consult? No Yes When? Dr.

Previous Allergy Evaluation? No Yes When? Dr.

Is patient on any medication at present? No Yes

Name of medicines:

Has patient used any other medicine in past for symptoms? No Yes

Name of medicines:

What brand of :

soap does patient wash with?

laundry detergent?

fabric softener?

bleach?

Are clothes dried on line or dryer?

SOCIAL/EMOTIONAL HISTORY/HABITS:

IS PATIENT OFTEN:

Depressed? No Yes

Anxious? No Yes

Irritable? No Yes

Jumpy? No Yes

Jittery? No Yes

Is concentration difficult? No Yes

Any sleep Difficulties? No Yes

Snoring? No Yes

FAMILY HISTORY:

Please indicate any of patient's family members (mom, dad, grandparents, siblings, aunts, uncles) who have:

Asthma

Bronchitis

Eczema

Hayfever

Hives

Other allergies

Other significant illness

ADULT:

Occupation of:

Self ______________________________________

Spouse ___________________________________

How many days of work are missed yearly? ____________

Exercise adequately? No Yes

How? ____________________________________

TEENS & ADULTS:

Has patient ever smoked? No Yes

# of packs daily?________ How long? ___________

if stopped, how long ago did patient stop? ____________

Does patient currently smoke? No Yes

Interested in stopping? No Yes

CHILD:

Occupation of mother: ___________________________

Occupation of father: ___________________________

School: Grade completed: ________________________

Marks are: above average average below average

Day Care? No Yes

Any problems in school/day care No Yes

How many days of school are missed yearly?

Is patient: hyper-active very active active couch potato

How does patient get along with peers? Good Poor

How does patient get along with adults? Good Poor

Does patient:

tire easily? No Yes

bed wet ? No Yes

get mad easily? No Yes

cry easily? No Yes

Any other family, social, emotional history or habits that you think are important?

SEASONAL VARIATION

Are symptoms present:

December-February	No Yes
March-May	No Yes
May-July	No Yes
July-August	No Yes
mid August-September	No Yes
October-November	No Yes

Circle months when symptoms are most severe.

PRECIPITATING FACTORS

Do the following have any effect on patient's symptoms:

Animals	No Yes
Colds/Upper Respiratory Infections	No Yes
Dampness (ex. basement, cabin)	No Yes
Dust	No Yes
Emotions (ex. laugh, cry)	No Yes
Exertion (ex. exercising, running)	No Yes
Food	No Yes
Perfumes/strong odor	No Yes
Rain	No Yes
Smoke	No Yes
Snow	No Yes
Temperature changes	No Yes
Other:	No Yes

PETS

Do you have pets? No Yes

For each pet indicate how long you have had it, where it spends its time, & is it ever in patient's bedroom?

Bird

Cat

Dog

Fish

Guinea pig/hamster/rabbit/etc.

Other

List any animals patient is frequently exposed to at relatives, friends, baby-sitters, etc.?

After being with an animal, does patient ever experience? (circle if yes)

Cough Wheeze Itchy or watery eyes Sneezing Stuffy nose Runny nose Rash Hives

If yes, specify animal:

ABOUT YOUR HOME

Have there been recent renovations? No Yes

Is it a: One family Two family Multifamily

Cape Colonial Ranch Split level Bi-level Other

How long have you lived here?

Do you heat with: Oil Gas Electric

Do you have: Radiators Forced hot air Baseboard

Kerosene heater Fire place Wood burning stove Other

Is house dry? No Yes

Is there a basement? No Yes Crawlspace? No Yes

Finished Unfinished Damp Dry

Rug in basement? No Yes Over concrete? No Yes

How much time does patient spend in basement? hrs. per week

Do you use a dehumidifier in house? No Yes

Where in house?

Do you use a humidifier in house? No Yes

Where in house?

Do you use a humidity gauge? No Yes What is usual humidity?

Does house have air conditioning? No Yes Room Central

Does anyone smoke in the house? No Yes Who?

What rooms? How often?

Does anyone living at home smoke outside the house? No Yes Who?

How often exposed at relatives, friends, baby-sitters, etc.?

What type of vacuum cleaner? Central Upright Canister HEPA

Where does patient spend most time, other than bedroom?

Living room Family room Other

In this room:

Furniture is made of: Upholstery Vinyl Other:

Floor is made of: Wood Concrete

Floor covering: None Tile Wall to wall rug Area rug

If rug, is it made of: Wool Synthetic Is pile: Low Medium High

Pad under rug? No Yes Horsehair Jute Foam Synthetic

PATIENT'S BEDROOM

Does patient have: Own room or share

Is bed: Canopy Bunk Single Crib Other:

What is mattress made of? Coil/spring Water Foam

How old is mattress? yrs.

Is it covered with an *"allergy(mite)-proof"* encasing? No Yes

What is pillow made of? Polyester Feather/down Cotton Foam

How old is pillow? yrs.

Is it covered with an *"allergy(mite)-proof"* encasing? No Yes

What are blankets made of? Polyester Feather/down Cotton Wool

How old is blanket? yrs.

Is it covered with an *"allergy(mite)-proof"* encasing? No Yes

Floor is made of: Wood Concrete

Floor covering: None Tile Wall to wall rug Area rug

If rug, is it made of: Wool Synthetic Is pile: Low Medium High

Pad under rug? No Yes Horsehair Jute Foam Synthetic

On the windows are: Curtains Drapes Shades Shutters

Mini-blinds Vertical blinds Other:

Clutter in room: Stuffed animals Books Dolls Toys Plants Posters

Banners Knick-knacks Open shelves Other:

FOOD SURVEY

How often are the following foods eaten each week?

Corn (includes corn syrup)	1-5	6-10	11+
Egg (includes frozen substitute)	1-5	6-10	11+
Dairy (milk, cheese, yogurt, ice cream)	1-5	6-10	11+
Peanut (includes peanut butter)	1-5	6-10	11+
Soy (tofu products, non dairy creamer)	1-5	6-10	11+
Tomato (includes soup, sauce, ketchup)	1-5	6-10	11+
Wheat (bagels, bread, cake, cookies, crackers,			
pancakes, pasta, pretzels, waffles)	1-5	6-10	11+
Fish or Shellfish	1-5	6-10	11+
Which kinds:			
Nuts (other than peanuts)	1-5	6-10	11+
Which kinds:			
Seeds (Sesame, Sunflower)	1-5	6-10	11+

How many ounces of milk are consumed daily?

Which type? Skim Low fat Whole Other

If formula milk or substitute, name:

List any foods eaten daily:

List any "craved" foods (have to have) and how often eaten each week.

List foods greatly disliked (can't stand).

Do any foods "disagree" with patient or cause reactions? No Yes

If yes, list foods and symptoms.

Is there anything else you would like us to know about the patient?

VACCINE		DATE
CHICKEN POX	disease	
	vaccine	
DTP	1	
Diphtheria	2	
Tetanus	3	
Pertussis	4	
	5	
TD		
Tetanus		
Diphtheria		
HAEMOPHILUS B		
HIB		
FLU VACCINE		

VACCINE	TYPE	DATE
PNEUMOCOCCAL VACCINE		
POLIO		
MEASLES, MUMPS, RUBELLA		
OTHER		
TUBERCULIN TEST		RESULTS / DATE

(1) Please write a brief summary about the illness that is bringing you to this office.

____

____

____

____

____

____

____

(2) What goals do you want to achieve by coming here?

____

____