WHAT SYMPTOMS BROUGHT YOU TO OUR OFFICE?

Reviewed by: _____
Date: _____

CURRENT SYMPTOMS:
( ) Watery Eyes
( ) Itching of the eyes
( ) Swelling of the eyelids
( ) Sneezing
( ) Runny nose
( ) Blocked nose
( ) Itching/rubbing of the nose
( ) Post-nasal drip
( ) Itching of the ears
( ) Itching of the mouth/throat
( ) Swelling of the lips
( ) Coughing
( ) Wheezing
( ) Shortness of breath
( ) Swelling of the body
( ) Rash
( ) Headache
( ) Nausea/stomach cramps
( ) Diarrhea

MEDICAL HISTORY:
( ) Ear Infection
( ) Hay fever
( ) Sinus infection
( ) Croup
( ) Asthma
( ) Bronchitis
( ) Pneumonia
( ) Hives
( ) Skin rashes/eczema
( ) Allergy skin tests, date: _____
( ) Allergy injections, date: _____
( ) Reaction to foods *
( ) Reaction to medicines *
( ) Reaction to insect stings *
*Please describe: _____
_____
_____
_____

IMMUNIZATIONS RECEIVED / UP TO DATE
( ) DPT/Tetanus/MMR
( ) HIB
( ) Polio
( ) Hepatitis
( ) Chicken Pox
( ) Flue Shot
( ) Pneumonia Shot

TB TEST:
( ) Positive ( ) Negative
Date: _____
Treatment: _____
_____
_____
_____

PAST MEDICAL HISTORY
Have you ever had:
( ) CHICKEN POX
( ) Problems with vision/hearing
( ) Heart disease/high blood pressure
( ) Diabetes/thyroid disorder
( ) Liver disease/hepatitis
( ) Tuberculosis
( ) Lung infections
( ) Serious infections
( ) Nervous system disorders
( ) Stomach/intestinal disorders
( ) Psychiatric evaluation/medicine

MEDICATIONS, CURRENT/PAST
(Now and in recent past)
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY:
Do any of your relatives have:

	Hay fever	Asthma	Eczema
( ) Mother	( )	( )	( )
( ) Father	( )	( )	( )
( ) Grandparent(s)	( )	( )	( )
( ) Sister(s)	( )	( )	( )
( ) Brother(s)	( )	( )	( )
( ) Other Relatives	( )	( )	( )

Do any of your relatives have:
( ) Emphysema
( ) Cystic fibrosis
( ) Lung disease

SOCIAL HISTORY
Job: _____
Hobbies: _____
Ethnic Origin: _____
( ) Sexually Active
( ) Pregnant: due date: _____
( ) Birth Control (Circle type used)
Condom/Sponge/Foam/Diaphragm
Birth control pills/Depo-Provera
Tubal ligation/Hysterectomy
( ) Menopause: last period _____ date

CLINICAL RESEARCH
( ) Previous subject
Date(s): _____
Where: _____

HOME ENVIRONMENT
Locale 1) What area is your home located? _____
Approx age of structure _____

Locale 2) If a second home, what area is home located: _____
Approx age of structure _____

	Locale 1	Locale 2
Central air cond.	( )	( )
Window air cond.	( )	( )
Swamp cooler	( )	( )
Central heating	( )	( )
Other heating	( )	( )
Carpeting	( )	( )
Fireplace/Stove	( )	( )
Flooding/Mold	( )	( )
Humidifier	( )	( )

In your Bedroom, indicate what applies:

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

SMOKING/EXPOSURE
( ) In house/car/at work
cig/day _____
yrs smoking _____
when last smoked _____
Alcohol/Drugs
# of drinks/beer/wine per week: _____
Date(s) for treatment/rehab alcohol/drug

_____ _____ _____
Print Patient Name Patient/Parent Signature Date