Asthma and Allergy of Idaho/Nevada

Name:______________________________ Date: ______________________________

Sex: ______________________________ Date of Birth: _______________________

Reason for visit: ____

Primary Care/Referring Provider: ____

Preferred Pharmacy: ____

Past Medical History: Please check each box that pertains to conditions you have been diagnosed with

- ☐ Allergic Rhinitis
- ☐ Anxiety
- ☐ Asthma
- ☐ Celiac Disease
- ☐ Chronic Bronchitis
- ☐ COPD
- ☐ Eczema
- ☐ Emphysema
- ☐ Food Allergy
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infections
- ☐ GERD/Acid Reflux
- ☐ Heart Attack
- ☐ Insect Allergy
- ☐ Nasal Polyps
- ☐ Sinus Trouble
- ☐ Urticaria
- ☐ Other: ________ _______________

Surgical Medical History: Please check each box that pertains to your past surgeries

- ☐ C-section
- ☐ Ear Tubes
- ☐ Eye Surgery
- ☐ Heart Surgery
- ☐ Hip Surgery
- ☐ Hysterectomy
- ☐ Knee Surgery
- ☐ Nasal Septal
- ☐ Nasal Turbinate
- ☐ Appendectomy
- ☐ Removal of Gall Bladder
- ☐ Adenoidectomy
- ☐ Tonsillectomy
- ☐ Other: _______

Family History:

	Mother	Father	Brother	Sister	Other Relatives
Allergic Rhinitis					
Environmental Allergies					
Asthma					
Food Allergies					
COPD					
Eczema					
Hay Fever					
Sinus Problems					
Recurrent Hives					
Other Health Issues:					

Social History:

- ☐ Never used tobacco products
- ☐ Former tobacco use --- How many years? ______What type of tobacco?_________How many cigarettes per day?___________What year did you quit? _______
- ☐ Current tobacco use --- How many years? ______How many cigarettes per day?________

Who smokes at home? __________________

Where do they smoke (please circle)? Indoors, Outdoors, Both

Marital Status (please circle): Single/Married/Divorced/Widowed

Occupation: ___________________________

Environmental History:

Type of Housing:

- ☐ Single Family Home
- ☐ Apartment
- ☐ Mobile Home
- ☐ Farm
- ☐ Dormitory
- ☐ Duplex
- ☐ Town House
- ☐ Other:

Type of Heating:

- ☐ Electric
- ☐ Gas
- ☐ Heat pump
- ☐ Pellet Stove
- ☐ Propane
- ☐ Wood Fireplace
- ☐ Wood Stove
- ☐ Other:

Indoor Pets/Animals:

- ☐ Cats
- ☐ Dogs
- ☐ Birds
- ☐ Gerbil/Guinea Pig

Age of home: _________

Does the home have mold? ___________If so, where is the mold located? ___________________

Type of Mattress (please circle): Feather, Foam, Pillow Top

Type of Pillows (please circle): Feather/Down, Foam, Memory Foam

Stinging Insect Reaction: Please fill out this section if applicable, otherwise leave blank

Suspected Insect Causing Reaction

- ☐ Do not know
- ☐ Honey Bee
- ☐ Bumble Bee
- ☐ Wasp
- ☐ Yellow Hornet
- ☐ Bald Faced Hornet

Symptoms Occurring After Sting

- ☐ Large localized swelling
- ☐ All over body hives
- ☐ Throat tightness
- ☐ Hoarseness
- ☐ Cough
- ☐ Nausea, vomiting, diarrhea
- ☐ Lightheadedness
- ☐ Low blood pressure

Review of Systems: Please check each box for any symptoms are you are currently experiencing

General:
- ☐ Chills
- ☐ Difficulty Sleeping
- ☐ Fatigue
- ☐ Fever
- ☐ Weight Gain
- ☐ Weight loss

Head:
- ☐ Dizziness
- ☐ Headache
- ☐ Migraine

Eyes:
- ☐ Watery Eyes
- ☐ Blurred Vision
- ☐ Eye pain
- ☐ Red Eyes
- ☐ Dry Eyes
- ☐ Itchy Eyes
- ☐ Swollen Eyes

Ears, Nose, Throat:
- ☐ Nasal Congestion
- ☐ Chronic Sinus Infection
- ☐ Loss of smell
- ☐ Ear Pain
- ☐ Frequent Ear Infections
- ☐ Bloody Nose
- ☐ Hoarseness
- ☐ Nasal Polyp(s)
- ☐ Itchy Nose
- ☐ Runny Nose
- ☐ Post Nasal Drip
- ☐ Sinus Pressure
- ☐ Throat/palate Itch

Respiratory:
- ☐ Asthma
- ☐ Chronic Bronchitis
- ☐ Cough
- ☐ Shortness of Breath
- ☐ Chest Tightness
- ☐ Wheezing

Cardiovascular:
- ☐ Chest Pain
- ☐ Palpitations
- ☐ Leg Swelling

Gastrointestinal:
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea

Skin:
- ☐ Eczema
- ☐ Flushing
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Dryness

Psychiatric:
- ☐ Anxiety
- ☐ Depression

Immunological:
- ☐ Difficult to treat infections

Exposures that make allergy symptoms worse:
- ☐ Spring (Mar – May)
- ☐ Summer (May – July)
- ☐ Late Summer (Jul-Aug)
- ☐ Fall (Aug – Oct)
- ☐ Winter (Nov-Feb)

Exposures that make asthma worse:
- ☐ Exercise or Running
- ☐ Viral URI's or Colds
- ☐ Temperature
- ☐ Strong odors
- ☐ Tobacco smoke
- ☐ Anxiety/stress

Other:

Have you lost time from school or work related to the reason you're being seen today? Yes / No
Have you been hospitalized for asthma, bronchitis, pneumonia, or other serious illness? Yes / No

Were you intubated? Yes / No
What condition were you hospitalized for? _________________________
How many days were you in the hospital? __________________________
How many hospitalizations have you had for this condition? __________

Medication Allergies:

List any medications that have caused an adverse reaction and please describe the type of reaction (i.e. rash, hives, and abdominal pain)

Medication Name	Type of Reaction

Current Prescription and Over the Counter Medications:

Please list your current medications, including all topical ointments, creams, herbal remedies, and oral supplements. If known, please include the reason for the medication.

Medication Name	Usual Dose and Frequency	Source of Medication (i.e. Prescriber)	Reason for Medication