□ Dr. Fadia Habib-Khazen
□ Dr. Housam Alasaly

Patient History

Patient Label Here

Section I Patient Information

Name _____ Date of Birth _____ Apt. Date _____

PCP _____ (Ph _____ Referring Physician _____ (Ph) _____

Medication Allergies _____ BP ____/____ Ht _____in Wt _____lbs

□ I am *on a beta blocker medication*

Section II Symptomology (*Check all that apply)*

Eye, Ear, Nose & Throat Symptoms	Chest Symptoms
Stuffy nose Sneezing Runny nose (front) Post nasal drip Puffy (swollen) eyes Nasal polyps Loss of smell Loss of taste Previous allergy evaluation Previous ENT evaluation Nose worse than eyes Eyes worse than nose Itchy eyes/watery eyes Itchy nose Itchy throat Itchy roof of mouth Itchy inside of ears Pain about the face Dark circles under eyes Sinus surgeries Symptoms worse inside house Symptoms worse outside house Excessive headaches Frequent ear infection Frequent sinus infections Nasal Drainage □discolored □clear Frequent throat infections Tonsils removed Adenoids removed How long have you had these symptoms?____	□ Shortness of breath □ Wheezing or chest tightness □ Frequent cough □ Dry or productive cough □ Frequent bronchitis □ History of asthma □ History of pneumonia □ ER visits (past 12 months) how many?____ □ Hospitalized for asthma □ Night-time asthma symptoms □ ICU admission for asthma □ Time lost for asthma □No □Yes If yes, Work days/yr ___ School days/yr ___ Steroid "bursts"/yr for asthma _____ □ Date of last steroid use _____ □ COPD, emphysema or chronic bronchitis □ Bronchiectasis □ Do you use albuterol inhaler? □No □Yes If yes, how often:____ Last time____

Section III Social

Do you smoke? □No □Yes If yes, How much do you smoke? ___ pkg/day Where do you smoke? □Inside □Outside □Car Do you drink alcohol? □No □Yes How much? ____ □day □week Do you use recreational drugs? □No □Yes What?_____ How often? _____ □day □week	

Section IV Factors Effecting Symptoms (*Circle all that apply - "N" for nose, "E" for eyes, and "C" for chest beside each that applies. Some may have multiple letters)*

N E C	Spring	N E C	Mowing lawn
N E C	Summer	N E C	Animals □cats □dogs □other
N E C	Fall	N E C	Foods
N E C	Winter	N E C	Moldy areas/windy days
N E C	Rapid climate change	N E C	Trees
N E C	Cold air	N E C	Weeds
N E C	Humidity	N E C	Exercise
N E C	Irritants (smoke, odors, sprays etc)	N E C	Medicines
N E C	Emotional stress	N E C	Colds/sinus infections
N E C	Perfumes	N E C	Laughter
N E C	Dusting (making bed)	N E C	Crying

Which ONE factor makes your symptoms the worst?

Section V Other Allergy Related Medical Problems *(Check all that apply)*

□	Hives	□	Contact allergy: □ poison ivy
□	Swelling		□ poison oak
□	Anaphylaxis		□ sumac
□	Eczema		□ nickel
□	Skin itching		□ soap
□	Chemical sensitivity		□ detergent
□	Insect allergy		□ cosmetics
□	Food allergy		□ other _____
□	Other skin rashes _____		

Section VI Medications *(List past and current medicines you have used for your nose, chest or skin problems)*

Name of Medicine	nose/eyes	Chest	Past	Current	Directions for use
	□	□	□	□	
	□	□	□	□	
	□	□	□	□	
	□	□	□	□	
	□	□	□	□	
	□	□	□	□	
	□	□	□	□	
	□	□	□	□	
	□	□	□	□	
	□	□	□	□	

Section VII Allergies to Medication

Medication Name	Date of Reaction	Type of Reaction

Section VIII Environmental History *(Check all that apply)*

Residence: □ house □ apartment □ age of building – how long have you lived there?_____
Cooling: □ air conditioner □ evaporative cooler
Water: □ damage to home *Any mold growth seen? □ yes □ no
Air Quality: □ air filter in bedroom □ house filter changed every _____ □ HEPPA filter □smoker in house
Cockroaches: □ seen in the house □ seen around the outside of house
Pets: □ none □ cat □ dog □ other _____ □ indoors □ outdoors □ in bedroom
Carpet: □ throughout □ in bedroom
Feather bedding: □ yes □ no
Stuffed toys in bedroom: □ yes □ no
Landscaping: □ grass □ desert □combination List trees
_____
Occupation: _____ Do symptoms increase at work? □ yes □ no
Hobbies: _____ Do symptoms increase during activity? □ yes □ no
How long have you lived in AZ? _____ Where did you live before? _____
Symptoms have: □ increased □ remained the same

Section IX Family History *(Check all that apply)*

	Allergic Rhinitis	Asthma	Eczema	Other
Father	□	□	□	□
Mother	□	□	□	□
Brother	□	□	□	□
Sister	□	□	□	□
Grandparents	□	□	□	□
Other	□	□	□	□

Section X Surgical History *(List any hospitalizations or surgeries and date)*

_____
_____
_____
_____

Section XI Immunizations

Have you had all the childhood immunizations? □ yes □ no *missing*
_____
What childhood diseases have you had? □ measles, □ mumps, □ chicken pox, □ other
_____
What shots did you last have_____ When and where? _____

Section XII Review of Systems *(Check all that apply)*

General	***Gastrointestinal***	***Genitourinary***	***Cardiovascular***	***Endocrinology***	***Neurological***
□ fatigue □ fever □ valley fever □ Tb □ achy Muscles □ weight Loss □ weight Gain □headache □migraine	□ nausea □ vomiting □ indigestion □ reflux □ burping □ heartburn □ ulcer □ abdominal pain □ cramps □ diarrhea □ constipation □ blood in stool □ dark or black stool □ hepatitis □failure to thrive □refuses food □ Other	□ frequency □ interruption □ incontinence □ blood in urine □ burning □ kidney problems □ prostate-cancer -enlargement □ Other	□ hypertension □ chest pain □ murmurs □ palpitations □ arrhythmia □ high cholesterol □ leg swelling □ Coronary Artery Disease □ Other	□ diabetes □ thyroid disease- hyper hypo □ osteoporosis □ Other	□ headaches- migraine sinus stress other □ seizures □ dizziness □ strokes □ fainting spells □ LOC (loss of consciousness)
Pulmonary	***Skin***	***Joint/ Muscles***	***Psychiatry***	***Eyes***	***Ears***
□ cough productive dry □ wheezing □ tightness □ pneumonia □ emphysema □ bronchitis □ blood in sputum □ chest pain	□ hives □ eczema □ rashes □ scaly patches □ itchy □ blisters □ psoriasis	□ lupus □ rheumatoid arthritis □ joint pain □ achy muscles □ fibromyalgia □ Other	□ depression □ anxiety □ bipolar disorder □ schizophrenia □ ADHD □ OCD □ Other	□ blurred vision □ tearing □ Itching □ double vision □ dryness □ cataracts □ glaucoma □ Other	□ itching □ ringing □ loss of hearing □ pain/ aching □ dizziness □ popping □ plugging
Hematological	***Other***				
□ anemia □ bruising □ clotting □ Other	□ immune □ recurrent infections □ weight loss				

Notes:

_____
Physician Signature