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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		
<input type="checkbox"/> I am on a beta blocker medication		

Section II Symptomology (Check all that apply)

Eye, Ear, Nose & Throat Symptoms	Chest Symptoms
<ul style="list-style-type: none"> <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Sneezing <input type="checkbox"/> Runny nose (front) <input type="checkbox"/> Post nasal drip <input type="checkbox"/> Puffy (swollen) eyes <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Loss of smell <input type="checkbox"/> Loss of taste <input type="checkbox"/> Previous allergy evaluation <input type="checkbox"/> Previous ENT evaluation <input type="checkbox"/> Nose worse than eyes <input type="checkbox"/> Eyes worse than nose <input type="checkbox"/> Itchy eyes/watery eyes <input type="checkbox"/> Itchy nose <input type="checkbox"/> Itchy throat <input type="checkbox"/> Itchy roof of mouth <input type="checkbox"/> Itchy inside of ears <input type="checkbox"/> Pain about the face <input type="checkbox"/> Dark circles under eyes <input type="checkbox"/> Sinus surgeries <input type="checkbox"/> Symptoms worse inside house <input type="checkbox"/> Symptoms worse outside house <input type="checkbox"/> Excessive headaches <input type="checkbox"/> Frequent ear infection <input type="checkbox"/> Frequent sinus infections <input type="checkbox"/> Nasal Drainage <input type="checkbox"/>discolored <input type="checkbox"/>clear <input type="checkbox"/> Frequent throat infections <input type="checkbox"/> Tonsils removed <input type="checkbox"/> Adenoids removed <input type="checkbox"/> How long have you had these symptoms? _____ 	<ul style="list-style-type: none"> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing or chest tightness <input type="checkbox"/> Frequent cough <input type="checkbox"/> Dry or productive cough <input type="checkbox"/> Frequent bronchitis <input type="checkbox"/> History of asthma <input type="checkbox"/> History of pneumonia <input type="checkbox"/> ER visits (past 12 months) how many? _____ <input type="checkbox"/> Hospitalized for asthma <input type="checkbox"/> Night-time asthma symptoms <input type="checkbox"/> ICU admission for asthma <input type="checkbox"/> Time lost for asthma <input type="checkbox"/>No <input type="checkbox"/>Yes If yes, Work days/yr _____ School days/yr _____ <input type="checkbox"/> Steroid "bursts"/yr for asthma _____ <input type="checkbox"/> Date of last steroid use _____ <input type="checkbox"/> COPD, emphysema or chronic bronchitis <input type="checkbox"/> Bronchiectasis <input type="checkbox"/> <input type="checkbox"/> Do you use albuterol inhaler? <input type="checkbox"/>No <input type="checkbox"/>Yes If yes, how often: _____ Last time _____

Section III Social

<p>Do you smoke? <input type="checkbox"/>No <input type="checkbox"/>Yes If yes, How much do you smoke? ____pkg/day Where do you smoke? <input type="checkbox"/>Inside <input type="checkbox"/>Outside <input type="checkbox"/>Car</p> <p>Do you drink alcohol? <input type="checkbox"/>No <input type="checkbox"/>Yes How much? _____ <input type="checkbox"/>day <input type="checkbox"/>week</p> <p>Do you use recreational drugs? <input type="checkbox"/>No <input type="checkbox"/>Yes What? _____ How often? _____ <input type="checkbox"/>day <input type="checkbox"/>week</p>	
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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)

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

Which ONE factor makes your symptoms the worst?

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

<input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> Eczema <input type="checkbox"/> Skin itching <input type="checkbox"/> Chemical sensitivity <input type="checkbox"/> Insect allergy <input type="checkbox"/> Food allergy <input type="checkbox"/> Other skin rashes _____	<input type="checkbox"/> Contact allergy: <input type="checkbox"/> poison ivy <input type="checkbox"/> poison oak <input type="checkbox"/> sumac <input type="checkbox"/> nickel <input type="checkbox"/> soap <input type="checkbox"/> detergent <input type="checkbox"/> cosmetics <input type="checkbox"/> other _____
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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
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Section VII Allergies to Medication

Medication Name	Date of Reaction	Type of Reaction

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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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparents	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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
<input type="checkbox"/> fatigue <input type="checkbox"/> fever <input type="checkbox"/> valley fever <input type="checkbox"/> Tb <input type="checkbox"/> achy Muscles <input type="checkbox"/> weight Loss <input type="checkbox"/> weight Gain <input type="checkbox"/> headache <input type="checkbox"/> migraine	<input type="checkbox"/> nausea <input type="checkbox"/> vomiting <input type="checkbox"/> indigestion <input type="checkbox"/> reflux <input type="checkbox"/> burping <input type="checkbox"/> heartburn <input type="checkbox"/> ulcer <input type="checkbox"/> abdominal pain <input type="checkbox"/> cramps <input type="checkbox"/> diarrhea <input type="checkbox"/> constipation <input type="checkbox"/> blood in stool <input type="checkbox"/> dark or black stool <input type="checkbox"/> hepatitis <input type="checkbox"/> failure to thrive <input type="checkbox"/> refuses food <input type="checkbox"/> Other	<input type="checkbox"/> frequency <input type="checkbox"/> interruption <input type="checkbox"/> incontinence <input type="checkbox"/> blood in urine <input type="checkbox"/> burning <input type="checkbox"/> kidney problems <input type="checkbox"/> prostate-cancer -enlargement <input type="checkbox"/> Other	<input type="checkbox"/> hypertension <input type="checkbox"/> chest pain <input type="checkbox"/> murmurs <input type="checkbox"/> palpitations <input type="checkbox"/> arrhythmia <input type="checkbox"/> high cholesterol <input type="checkbox"/> leg swelling <input type="checkbox"/> Coronary Artery Disease <input type="checkbox"/> Other	<input type="checkbox"/> diabetes <input type="checkbox"/> thyroid disease- hyper hypo <input type="checkbox"/> osteoporosis <input type="checkbox"/> Other	<input type="checkbox"/> headaches- migraine sinus stress other <input type="checkbox"/> seizures <input type="checkbox"/> dizziness <input type="checkbox"/> strokes <input type="checkbox"/> fainting spells <input type="checkbox"/> LOC (loss of consciousness)

Pulmonary	Skin	Joint/ Muscles	Psychiatry	Eyes	Ears
<input type="checkbox"/> cough <input type="checkbox"/> productive dry <input type="checkbox"/> wheezing <input type="checkbox"/> tightness <input type="checkbox"/> pneumonia <input type="checkbox"/> emphysema <input type="checkbox"/> bronchitis <input type="checkbox"/> blood in sputum <input type="checkbox"/> chest pain	<input type="checkbox"/> hives <input type="checkbox"/> eczema <input type="checkbox"/> rashes <input type="checkbox"/> scaly patches <input type="checkbox"/> itchy <input type="checkbox"/> blisters <input type="checkbox"/> psoriasis	<input type="checkbox"/> lupus <input type="checkbox"/> rheumatoid arthritis <input type="checkbox"/> joint pain <input type="checkbox"/> achy muscles <input type="checkbox"/> fibromyalgia <input type="checkbox"/> Other	<input type="checkbox"/> depression <input type="checkbox"/> anxiety <input type="checkbox"/> bipolar disorder <input type="checkbox"/> schizophrenia <input type="checkbox"/> ADHD <input type="checkbox"/> OCD <input type="checkbox"/> Other	<input type="checkbox"/> blurred vision <input type="checkbox"/> tearing <input type="checkbox"/> Itching <input type="checkbox"/> double vision <input type="checkbox"/> dryness <input type="checkbox"/> cataracts <input type="checkbox"/> glaucoma <input type="checkbox"/> Other	<input type="checkbox"/> itching <input type="checkbox"/> ringing <input type="checkbox"/> loss of hearing <input type="checkbox"/> pain/ aching <input type="checkbox"/> dizziness <input type="checkbox"/> popping <input type="checkbox"/> plugging
Hematological <input type="checkbox"/> anemia <input type="checkbox"/> bruising <input type="checkbox"/> clotting <input type="checkbox"/> Other	Other <input type="checkbox"/> immune <input type="checkbox"/> recurrent infections <input type="checkbox"/> weight loss				
		<i>Notes:</i>			

Physician Signature