□ Dr. Fadia Habib-Khazen
□ Dr. Housam Alasaly
□ Veena Krause, FNP

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

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 **IN THE PAST MONTH**)*

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