ALLERGY AND ASTHMA HISTORY

Patient: Please fill out this side

Name _____

Date _____ Date of Birth _____ Age _____

Phone: Home _____ Work _____ **Sex M / F**

Cell: _____ Email: _____

Address _____

City, State, Zip _____

Occupation/grade level _____

Primary Care Clinician _____

Pharmacy _____

Referral source (MD,NP, **phone book, internet, insurance, other)**

_____

Recent Lab: ❑ yes ❑ no If yes, where: _____

The main reasons for coming here are:

_____

_____

_____

At what age did this first occur? _____

What are the goals that you wish to achieve here?

_____

_____

_____

Symptoms:

LUNGS/RESPIRATORY SCREENING TEST

In the past 12 months, have you had:

❑ Recurrent episodes of wheezing or shortness of breath
❑ Colds that go to the chest
❑ Coughing, wheezing or short/tightness with colds, animals, or exercise
❑ A need for medication to help breathing

In the past 4 weeks, have you had cough, wheezing or shortness of breath:

❑ That has awakened you at night/early morning
❑ After running/physical activity
❑ History of Asthma in the past

*If you answered yes or have asthma, fill out the **Asthma Questionaire**, otherwise go to the next page.*

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Satellite Clinics: Eagle, Nampa, & Caldwell

Asthma Questionaire:

ASTHMA SYMPTOMS/CURRENT CONTROL

Age Asthma symptoms started: _____

Age Asthma was diagnosed: _____

Asthma symptoms: _____

❑ Cough ❑ Wheezing ❑ Shortness of breath
❑ Chest tightness ❑ Increased sputum
❑ These symptoms occur at night/early morning
❑ Is you asthma getting worse over time? ❑ Yes ❑ No

HISTORY OF EARLY LUNG INJURY:

❑ Premature birth ❑ Home use oxygen ❑ 2nd hand smoke
❑ Pneumonia/bronchitis ❑ Chemical lung injury

PATTERN OF SYMPTOMS:

Worse Season:
❑ Spring ❑ Summer ❑ Fall ❑ Winter ❑ Year round

How often do you have Symptoms? _____ X per
❑ Week ❑ Month ❑ Year

PRECIPITATING/AGGRAVATING FACTORS:

❑ Colds/URI ❑ Sinusitis ❑ Allergies ❑ Animals
❑ Dust ❑ Cold air ❑ Night time ❑ Stress ❑ Pollution
❑ Smoke ❑ Fragrance/odors ❑ Exercise ❑ Workplace
❑ School ❑ Weather changes
❑ Drugs (aspirin/beta blockers etc.)
❑ Endocrine factors(menses, pregnancy, thyroid)

Other: _____

Do your asthma symptoms improve when you are on vacation for over a week? ❑ Yes ❑ NO

Physician Notes:

_____

_____

_____

COUGH ❑**Yes** ❑ **No** (If no, go to the next section)

- ❑ Continuous
- ❑ Day time
- ❑ Night time
- ❑ Barking
- ❑ Interferes with sleep
- ❑ Dry with no sputum
- ❑ With sputum
- ❑ Deep
- ❑ Exercise makes worse

NOSE ❑ **Yes** ❑ **No** (If no, go to the next section)

- ❑ Nasal congestion
- ❑ Itching
- ❑ Sneezing
- ❑ Post nasal drainage
- ❑ Headaches
- ❑ Bad breath
- ❑ Facial discomfort
- ❑ Clear discharge
- ❑ Thick discharge
- ❑ Mouth breathing
- ❑ Snoring
- ❑ Nose bleeds
- ❑ Rubbing of nose
- ❑ Complete loss of sense of smell

ARE THESE SYMPTOMS WORSE (If no, go to the next section)

Spring ❑ Summer ❑ Fall ❑ Winter ❑

Exposure To:

❑ Animals ❑ Irritants ❑ Pollens/Molds ❑ Other_____

EYES ❑ **Yes** ❑ **No** (If no, go to the next section)

- ❑ Itching
- ❑ Running
- ❑ Swelling
- ❑ Redness

THROAT ❑ **Yes** ❑ **No** (If no, go to the next section)

- ❑ Itching
- ❑ Loss of voice (hoarseness)
- ❑ Lump in throat/ throat closing
- ❑ Sore throat
- ❑ Throat clearing
- ❑ Regurgitation of food into throat

EARS ❑**Yes** ❑ **No** (If no, go to the next section)

- ❑ Popping
- ❑ Itching
- ❑ Hearing loss
- ❑ Dizzy
- ❑ Infections

FOOD ALLERGIES/SYMPTOMS ASSOCIATED WITH EATING A CERTAIN FOOD ❑**Yes** ❑ **No** (If no, go to the next section)

- ❑ Itching of mouth or throat
- ❑ Swollen lips/tongue
- ❑ Hoarseness/change of voice
- ❑ Hives/swelling
- ❑ Nasea, vomiting, diarrhea or cramps
- ❑ Wheezing/shortness of breath
- ❑ Loss of consciousness
- ❑ Light headed

Foods suspected of causing allergic reaction:

_____

_____

_____

POSSIBLE ACID REFLUX/THROAT REFLUX ❑**Yes** ❑ **No** (If no, go to the next section)

- ❑ Heartburn
- ❑ Regurgitation of food into throat
- ❑ Acid taste in mouth
- ❑ Throat Clearing
- ❑ Hoarseness
- ❑ Sore throat

Physician Notes:

HIVES OR URTICARIA (WELTS)

❑**Yes** ❑ **No** (If no, go to the next section)

Describe the appearance (size, location):_____

_____

Will scratching cause the hives? ❑ **Yes** ❑ **No**

Frequency: _____

Associated symptoms:

- ❑ Itching
- ❑ Bruising
- ❑ Swollen lips
- ❑ Joint aches
- ❑ Stomach pain
- ❑ Pain
- ❑ Pigment afterwards
- ❑ Last >24 hours
- ❑ Wheezing
- ❑ Fever

Possible trigger factors:

- ❑ Medications (Rx/OTC)
- ❑ Pressure
- ❑ Heat
- ❑ Emotion
- ❑ Food supplements
- ❑ Cold
- ❑ Exercise

DERMATITIS or ECZEMA (rash)

❑**Yes** ❑ **No** (If no, go to the next section)

Describe the appearance: _____

_____

Location:_____

Age of onset:_____

- ❑ Itching
- ❑ Weeping

Possible trigger factors:

- ❑ Foods
- ❑ Medications
- ❑ Animals

ALLERGY TO INSECT STINGS/Does not include other bug bites

❑ **Yes** ❑ **No** (If no go to the next section)

- ❑ Local reaction
- ❑ Hives
- ❑ Cough/wheezing
- ❑ Loss of consciousness/light headed
- ❑ Large Swelling
- ❑ Other:_____

Suspected insect:

- ❑ Honey bee
- ❑ Hornet
- ❑ Other
- ❑ Yellow Jacket
- ❑ Wasp
- ❑ Fire Ants

Site of sting:_____

Onset of symptoms:_____

Duration of symptoms:_____

Medications used:_____

FREQUENT INFECTIONS

❑ **Yes** ❑ **No** (If no, go to the next section)

- ❑ Chronic infections
- ❑ Incomplete clearing of infection
- ❑ Severe skin rashes
- ❑ Growth failure
- ❑ Recurrent infections
- ❑ Poor response to treatment
- ❑ Chronic Diarrhea
- ❑ Other:_____

Location of infection:

- ❑ Pneumonia
- ❑ Sinus infections
- ❑ Ear infections
- ❑ Skin
- ❑ Other:_____

Physician Notes:

All current medicines: (please include all inhalers & sprays, as well as any herbs/supplements/alternative medicines and CPAP)

Medication	Please include dose:			Physicians Notes
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____
_____	_____	_____	times per day	_____

Please list all medications that you have taken in the last two years.

Asthma medication you have used in the past:_____Antihistamines used in the past:_____

Nasal sprays used in the past:_____Eyedrops used in the past:_____

Current environment:

Age of home: _____ Number of rooms: _____ Time at current residence:_____

Animals	❑ YES	❑ NO
Outdoor cat now	❑	
Indoor cat now	❑	
Indoor cat in the past	❑	
Outdoor dog now	❑	
Indoor dog now	❑	
Indoor dog in the past	❑	
Birds now or in past	❑	
Other animals	❑	

Household	❑ YES	❑ NO
Forced air heat	❑	
Rural living area	❑	
Swamp cooler	❑	
Smoking exposure	❑	

Humidity Problems	❑ YES	❑ NO
Moisture water damage	❑	
Mold growth	❑	

Other Triggers	❑ YES	❑ NO
Time in daycare	❑	
Animals in daycare	❑	
Latex/rubber exposure	❑	

Is there anything in your home or at work that triggers your allergies or asthma?_____

_____

_____

Previous residences:

City, State	from:	to:	City, State	from:	to:
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Past Allergy and Asthma History :

	YES	NO
Have you had previous allergy testing?	❑	❑

If you answered yes, then please answer the following questions:

	YES	NO		YES	NO
Previous allergy shots?	❑	❑	Still on allergy shots?	❑	❑
Allergy shots have helped?	❑	❑	Frequency of allergy shots _____		
Any minor reactions?	❑	❑	Previous chest x-ray?	❑	❑

If you have had any major reactions, please describe? _____

Past Medical History:

Chronic Health Conditions

- ❑ High blood presure
- ❑ Heart disease
- ❑ Thyroid
- ❑ Diabetes
- ❑ Other:_____

_____

_____

Surgery:

- ❑ Appendectomy
- ❑ C-Section
- ❑ Hysterectomy
- ❑ Ear tubes
- ❑ Sinus
- ❑ Tonsils
- ❑ Adenoids
- ❑ Gallbladder

❑ Other:_____

_____

_____

Recent emergency visits last two years:_____

_____

Immunization Adverse Reactions **❑ Yes ❑ No**

Influenza shot this year ❑ Yes ❑ No When:_____ **Prevnar shot ❑ Yes ❑ No When:**_____

Pneumonia shot ❑ Yes ❑ No When:_____ **Are immunizations up to date ❑ Yes ❑ No When:**_____

Drug Allergies

Drug		*Symptom*	*Drug*		*Symptom*
_____	caused	_____	_____	caused	_____
_____	caused	_____	_____	caused	_____

FAMILY HISTORY:

	Nasal Allergies	Asthma	Food Allergies	Eczema	Emphysema	Hives
Father:	❑	❑	❑	❑	❑	❑
Mother	❑	❑	❑	❑	❑	❑
Brother(s):	❑	❑	❑	❑	❑	❑
Sister(s)	❑	❑	❑	❑	❑	❑
Children	❑	❑	❑	❑	❑	❑
Extended Family	❑	❑	❑	❑	❑	❑

Family history of severe infections, unexplained deaths, cystic fibrosis, lupus, thyroid disease, celiac/gluten or rheumatoid arthritis? ❑ YES ❑ NO

SOCIAL HISTORY:

Primary residence is: ❑ one home
❑ split between homes

Number of individuals in the household: _____

Current occupation/grade level (if student): _____

Preschool or Daycare: Yes ❑ No ❑

School/work loss from asthma/nasal symptoms: Yes ❑ No ❑

Do you have medical insurance: Yes ❑ No ❑

Other relevant social factors: _____

What are your hobbies and interests outside of work, school and family?

_____

Habits:	**YES**	**NO**
Alcohol consumption	❑	❑_____ drinks per week
Smoking currently	❑	❑ For _____ years ___ ppd
Smoking in past	❑	❑ For _____ years ___ ppd
Electronic Cigarettes (Vaping)	❑	❑
Marijuana use	❑	❑

REVIEW OF SYSTEMS: (check all that apply to you)

General
- ❑ Fatigue/localized weakness
- ❑ Fever/chills
- ❑ Hot flashes
- ❑ Night sweats
- ❑ Unexplained weight loss
- ❑ Weight gain

SKIN
- ❑ Rash
- ❑ Wounds or Sores
- ❑ Swelling of the lips/face

SleepApnea
- ❑ Loud snoring
- ❑ Interrupted breathing during sleep
- ❑ Using CPAP

Cardiac
- ❑ Chest pain
- ❑ Palpitations
- ❑ Leg swelling
- ❑ Other heart condition:_____

GI
- ❑ Food getting stuck in throat
- ❑ Heartburn/reflux
- ❑ Abdominal pain
- ❑ Nausea/vomiting
- ❑ Diarrhea/constipation
- ❑ Liver disease

GU
- ❑ Painful urination
- ❑ Blood in the urine

Hematologic
- ❑ Swollen lymph nodes
- ❑ Anemia

Endocrine
- ❑ Hot intolerance
- ❑ Cold intolerance
- ❑ Diabetes/Pre-Diabetes
- ❑ Thyroid Problems

Neuro
- ❑ Memory problems
- ❑ Headache
- ❑ Numbness
- ❑ Dizziness/Vertigo
- ❑ Problems with balance

Musculo/skeletal
- ❑ Joint pain/muscle pain
- ❑ Joint swelling

Psychiatric
- ❑ Depression
- ❑ Anxiety
- ❑ Other psychiatric condition

Physician Notes:

Name of person filling out this history form (print):_____

Relationship to patient if not the patient: _____