Appt Date:_____
Appt Time:_____
Doctor:

AAIR ALLERGY/ASTHMA PATIENT MEDICAL HISTORY

Last Name:_____ First:_____ MI____ Date:_____ Date of Birth:_____ Age:_____ Sex:___
Address:_____ Phone:_____
Primary doctor_____ Referred by:_____ Type of Insurance:_____
Other doctors seen and specialty: _____
Other Family members seen by AAIR:_____ doctor seen:_____
Parent's names (if minor) _____ Person filling out form: _____

Welcome to our medical practice. *Please complete this questionnaire* ***completely prior to our visit.*** ***THANK YOU!!***

I. DESCRIBE YOUR REASON(S) FOR THIS VISIT/CONCERNS: _____

_____
_____
_____
_____
_____
_____

II. SYMPTOMS: Please check all that apply.

NOSE/SINUSES: Age of onset of nasal symptoms _____

1. Are nasal symptoms ☐Progressively worsening ☐Persisting ☐Getting better ☐_____
2. Symptoms: ☐Nasal blockage ☐Nasal congestion ☐Sneezing ☐Sniffling ☐Itchy nose ☐Runny nose ☐Loss of smell ☐loss of taste ☐Nasal speech ☐hoarse voice ☐Snoring
3. Color of nasal drainage ☐Clear ☐White ☐Yellow ☐Green ☐Nose bleeds how often?_____
4. Post-nasal drainage/drip - ☐Constant ☐Periodic ☐Occasional ☐Never ☐When lying down
5. Clearing of throat - ☐Constant ☐Frequent ☐Occasional ☐awakening with mucus in throat
6. Headaches/pressure ☐N ☐Y Where? ☐Around/behind eyes ☐forehead ☐face/cheeks ☐behind head/neck how often?_____
   Have you been diagnosed with migraine headaches? ☐N ☐Y triggers_____ what helps?_____
7. Have you been diagnosed with sinus infections requiring antibiotics? ☐N ☐Y # of infections per year_____
   date of last infection_____ How treated (with what antibiotic/how many days) _____
   Do symptoms completely clear with antibiotics? ☐Y ☐N ☐minimal improvement ☐Temporary complete improvement
8. Have you ever had: ☐Broken nose ☐Deviated nasal septum ☐Sinus surgery ☐Nasal surgery ☐Tonsils removed ☐Adenoids removed ☐Nasal polyps Details (&date) _____
   ☐Sinus Xray/CT? where_____ results_____
9. Are Nasal symptoms - ☐All year ☐Spring ☐Summer ☐Fall ☐Winter Which is worst? _____

LUNGS: Age of onset of earliest lung/chest symptoms _____

1. Symptoms: ☐Cough ☐Difficulty breathing ☐Shortness of breath ☐Chest tightness ☐Wheezing ☐Chest pain
2. Are symptoms worse ☐getting air in ☐getting air out ☐Both breathing in and out ☐when lying down
3. Do you have chest symptom with: ☐exercise/activity ☐with all/most infections ☐At Night ☐weather change ☐with anxiety ☐Outdoors in pollen season ☐Indoors ☐cold air ☐at work Other_____
4. Do colds/infections settle in your chest? ☐All ☐Most ☐Some ☐Never
   Do infections tend to linger in chest for extended period? ☐N ☐Y how long?_____
5. Ever diagnosed with: Bronchitis? ☐N ☐Y how many per year?_____
   Pneumonia? ☐N ☐Y how many overall?_____ by Chest Xray? ☐Y ☐N
6. Do lung symptoms occur - ☐All year round ☐Spring ☐Summer ☐Fall ☐Winter Which is worst? _____
7. How many attacks of difficulty breathing in last one year? _____ how long do they last?_____
   How long does each attack last? ☐Minutes to hours ☐Days ☐More than a week ☐Weeks ☐Months
8. How many times do you have symptoms **per week** on average? Daytime_____ Nighttime_____
9. Have you ever been given an inhaler or nebulizer? ☐Y ☐N _____
   How many times do you use a rescue inhaler or nebulizer **per week**_____ ☐only with infections
   Does it improve symptoms? ☐Y ☐N ☐temporarily ☐incompletely
10. How much time passes between attacks with no symptoms or need for inhalers?_____
11. Approximate number of school/work days missed per year due to chest symptoms:_____
12. Number of Emergency room/Urgent Care visits for breathing _____ date of most recent _____
    Number of Hospitalizations for breathing _____ date of most recent _____
13. Ever been given oral steroids for breathing? (orapred, prednisone, medrol, ect.) ☐N ☐Y which one_____
    # of times last yr_____ # of times lifetime_____ date of most recent _____
14. When was your last Chest X-ray? _____ results_____
15. Do you have ☐heartburn ☐frequent belching ☐Sour/brash taste in mouth how often?_____

Name_____

EYES: Age of onset of earliest symptoms _____

1. Symptoms: ☐Redness ☐Itchy ☐Watery ☐Mattering ☐Puffiness around eyes ☐Darkening under/around eyes
2. Are symptoms - ☐All year ☐Spring ☐Summer ☐Fall ☐Winter Which is worst? _____
3. Are eye symptoms worse when nasal symptoms are bad? ☐Yes ☐No
4. Do you wear contacts? ☐Yes ☐No Change how often?_____ Date of last eye exam _____

EARS: ☐Pain ☐Itching ☐Popping ☐Plugging ☐Decreased hearing ☐Infections , # per year_____ Ear tubes ☐Y ☐N date_____

TRIGGERS: **Which of the following exposures seem to worsen your NASAL, EYE, or LUNG symptoms?**

☐Outdoors ☐Indoors ☐House work/Dusting ☐Lawn mowing ☐Yard work/Gardening ☐contact with grass ☐Smoke ☐Exercise
☐Stress ☐Perfumes/Strong odors ☐Paint ☐Cosmetics ☐News print ☐Wet weather ☐Hot weather ☐Humidity ☐Cold air
☐Rapid temperature changes ☐air conditioning ☐Barns ☐Hay ☐Mold/Mildew ☐Raking leaves ☐Damp places/basements
☐Cats ☐Dogs ☐Other animals _____ ☐Alcoholic beverages ☐Aspirin/pain medications ☐Spicy foods
☐Worse at work ☐Vacation: where better?_____ Where worse?_____
☐food triggers_____ ☐other triggers_____

HIVES/SWELLING: (if hives/swelling not an active concern, may skip this section)

Date of onset_____ Currently active ☐Yes ☐No

1. Symptoms with attack - ☐Hives ☐facial swelling ☐Lip swelling ☐Tongue swelling ☐Itching ☐Choking ☐Breathing trouble ☐Abdominal pain ☐Nausea ☐Nasal symptoms ☐Throat Swelling
2. Location - ☐Face ☐Trunk ☐Arms ☐Legs ☐Hands ☐Feet ☐Other_____
3. Frequency: ☐Daily ☐Weekly ☐Monthly ☐_____ How long does an attack last?_____
4. Worse with: ☐Cold exposure ☐Heat ☐Exercise ☐Sweating ☐Hot shower/bath ☐Swimming ☐Outdoors ☐Stress ☐Pressure/prolonged sitting ☐Rubbing/scratching ☐friction/clothing contact ☐vibration ☐wind ☐animal exposure
5. Worse: ☐Mornings ☐Evenings ☐Nighttime ☐After meals ☐with menstrual cycle ☐pregnancy
6. Any New foods/ingestions related to hives_____
7. New/Recently added Medications_____
8. New Herbal/nutritional Supplements_____
9. Do you take over the counter pain medications? (Ibuprofen/Alleve)? How often?_____ Any relation to Hives? ☐Y ☐N
10. Any illnesses/infections prior to/during outbreak of hives? _____
11. Recent insect stings/bites ☐No ☐Yes _____
12. Latex exposure? ☐No ☐Yes where/what _____
13. Ever Travel out of Country? where/when _____
14. Ever have blood transfusion? ☐Y ☐N when_____
15. Do you have ☐ongoing sinus symptoms ☐dental problems/tooth pain _____
16. New: ☐Soaps ☐Lotions ☐Detergents ☐Makeup ☐Sunscreen ☐Fabric Softener ☐Other contacts_____
17. List all known or suspected things that may cause your hives_____
18. Description of hive History: _____
19. What do you do/take to treat hives?_____

ECZEMA: **Any current OR previous history of eczema?** ☐No ☐Yes: Age of onset_____ Still present? ☐Yes ☐No

1. Areas currently involved _____
2. List all known or suspected triggers that aggravate eczema _____
3. Have you noticed any food correlation? ☐N ☐Y:_____
4. When time of year is eczema worst? _____ When better? _____
5. Moisturizing cream used: _____ How often?_____
6. Other treatments used/tried: _____
7. Bathing: frequency _____times per week Approximate duration _____minutes water temperature_____

FOOD ALLERGY: Do you suspect any foods cause adverse reaction/contribute to symptoms? ☐Yes ☐No

1. List all suspected foods and reactions: _____
2. What reaction? ☐Hives ☐Swelling where_____ ☐breathing trouble ☐Throat tightness/itching ☐eczema ☐Rash ☐Abdominal Pain ☐gas/bloating ☐Vomitting ☐Headaches ☐Nasal symptoms ☐Other_____
3. How soon after ingestion do reactions occur? _____
4. List all foods <u>currently</u> avoiding strictly_____ <u>Previously</u> tried to avoid _____
5. Have you noticed improvement with avoidance? Which?_____

CONTACT ALLERGY: **1.** Do you have skin rashes after contact with: ☐Latex ☐Detergents ☐Makeup ☐Sunscreen ☐Poison Ivy ☐Poison Oak/Sumac ☐Exposures at work ☐Metals (Jewelry) type_____ ☐Other _____

2. List names of any chemical, drug, ointments, etc., that produce skin rash _____
3. List all reactions: _____

Name_____

INSECT STINGS:

1. Have you ever had a reaction from the following insect sting or bite:
   ☐Honey/Bumble Bee ☐ Wasp ☐Yellow jacket ☐Hornet ☐Flea ☐Mosquito ☐Fire ant ☐Other _____
2. Reactions: ☐Mild-Moderate swelling at site ☐Severe swelling at site ☐Generalized itching ☐Hives ☐Breathing trouble
   ☐Tongue swelling ☐Lip swelling ☐Throat swelling/tightness ☐Nasal congestion/drip ☐Abdominal pain/cramps
   ☐Shock/low blood pressure ☐Loss of consciousness ☐Other_____
3. When was reaction?_____ How soon after sting did symptoms begin?_____
4. Have you been stung since? ☐Y ☐N any reaction?_____
5. List any treatment you have received for an insect sting (hospitalization, medicines, etc.) _____
   _____

III. MEDICAL HISTORY: Please list **ALL medical conditions/history/diagnosis**

Medical Condition/Diagnosis	Treatment	Medical Condition/Diagnosis	Treatment
1._____	_____	5._____	_____
2._____	_____	6._____	_____
3._____	_____	7._____	_____
4._____	_____	8._____	_____

PAST SURGICAL HISTORY: Please list **ALL Surgeries, and hospitalizations.**

Surgery	Treatment	Surgery	Treatment
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

IV. PREVIOUS ALLERGY EVALUATION & TREATMENT:

1. Have you had a previous allergy evaluation? ☐Y ☐N Doctors/Cities_____ Dates:_____
2. What were you allergic to? _____
3. Did you receive immunotherapy (allergy shots)? ☐Yes ☐No Dates:_____ How many yrs_____
4. Did your symptoms improve while on injections? ☐Yes ☐No _____

V. DRUG ALLERGIES/ADVERSE REACTIONS Please list all drugs & **describe what reaction occurred**

☐**No Known Drug Reactions**

Medication:	Reaction:	Medication:	Reaction:
1._____	_____	4._____	_____
2._____	_____	5._____	_____
3._____	_____	6._____	_____

VI. CURRENT MEDICATIONS: Please list **ALL medications CURRENTLY** being used, either regularly or intermittently.

* list **ALL** prescription, non-prescription, herbal, and over the counter medications, as well as all inhalers, creams/ointments, sprays, pills

Medication:	Dose / Frequency:	Date started(estimate):	Reason for use:
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____
6._____	_____	_____	_____
7._____	_____	_____	_____
8._____	_____	_____	_____
9._____	_____	_____	_____(use back if additional medications)

Have you ever been prescribed an EpiPen (adrenalin/epinephrine)? ☐Yes ☐No Reason_____

PREVIOUS Medications used/tried:

☐Inhalers/nebulizers (please list names of all used) _____
☐Benadryl ☐Claritin/Loratadine ☐Allegra/fexofenadine ☐Zyrtec/cetirizine ☐Singular _____
☐Nasal sprays (please list names of all used) _____
☐Over the counter medications (list all) _____
☐Ointments/creams/topical medications (list all) _____
☐How many courses of antibiotics given in last yr? _____ Reasons:_____
☐**All** other medications taken in last year_____

VII. IMMUNIZATION HISTORY: Are immunizations up-to-date? ☐Yes ☐No. **Please provide records**

If not, which vaccinations were missed/declined_____

1. Last flu shot _____
2. Ever received pneumonia vaccine (pneumovax or prevnar)? ☐Yes ☐No Year last received:_____
3. Ever have an adverse reaction to a routine vaccination? ☐Y ☐N describe_____

Name_____

VIII. FAMILY HISTORY: Please check all conditions that occur in your family and indicate who is/was affected.

	Mother	Father	Brother	Sister	Child	Grandparent	
Asthma	☐	☐	☐	☐	☐	☐	info_____
Nasal Allergies	☐	☐	☐	☐	☐	☐	info_____
Sinus Disease	☐	☐	☐	☐	☐	☐	info_____
Food Allergy	☐	☐	☐	☐	☐	☐	info_____
Eczema	☐	☐	☐	☐	☐	☐	info_____
Hives / swelling	☐	☐	☐	☐	☐	☐	info_____
Insect sting allergy	☐	☐	☐	☐	☐	☐	info_____
Immune deficiency	☐	☐	☐	☐	☐	☐	info_____
COPD/emphysema	☐	☐	☐	☐	☐	☐	info_____
Cancer	☐	☐	☐	☐	☐	☐	info_____
Heart disease/stroke	☐	☐	☐	☐	☐	☐	info_____

Other family history:_____

IX. SMOKING HISTORY/EXPOSURE: ☐Current smoker ☐Former smoker ☐2nd hand smoke exposure whom?_____

1. How many years total?_____ How many packs per day on average?_____ When did you quit?_____
2. Anyone who lives in your house or visits often a smoker? (**Even outdoors**) ☐Y ☐N Who?_____
3. Did parents/caregivers smoke growing up? ☐Yes ☐No Who? _____

X. ENVIRONMENTAL/ SOCIAL HISTORY: ☐Married ☐Single

1. Occupation_____ Parents occupations (if minor) _____
   ☐Attending school _____ Grade_____ ☐Attend Day care/Babysitter? # of days per week_____
   If minor, and parents are separated, number of days/month at: Mother's home_____ Father's home_____
   ☐Hobbies_____ ☐Chemical exposures at home or work _____
2. PETS- What pets do you own or have significant exposure to?
   ☐Cat number_____ #of years_____ ☐indoor ☐outdoor ☐Sleeps in Bedroom ☐Ever goes in Bedroom
   ☐Dog number_____ #of years_____ ☐indoor ☐outdoor ☐Sleeps in Bedroom ☐Ever goes in Bedroom
   ☐Horse ☐Rabbit ☐Hamster ☐Guinea Pig ☐Cow ☐Pig ☐Sheep ☐Goat ☐Birds what type?_____ ☐Other_____
3. What animals are you exposed to: At parents/relatives/friends homes? _____ how often?_____
   At school/daycare/babysitters? _____ how often?_____
   Ever exposed to/had in home?: ☐Mice ☐Fleas ☐Cockroaches ☐Rats _____
4. How long have you lived in Upstate NY?_____ Years in current home_____ Age of home _____
   Previous locations lived_____ date of last move:_____
5. Any damp/musty areas in home? ☐N ☐Y where? _____ ☐Any prior water damage?_____
   ☐Any visible mold?_____ ☐Any prior mold removal? ☐N ☐Y how fixed? _____
   Basement: ☐Finished basement ☐Bedroom in basement ☐playroom in basement ☐office in basement ☐_____
   ☐have Dehumidifier ☐Ducts last cleaned_____ ☐Furnace filter changed_____
6. Cooling: ☐Central air conditioner ☐Room air conditioner ☐Home windows open when hot
   Heating: Type of heating system:_____ ☐Wood burning stove ☐Fireplace
7. Do you live: ☐near open fields ☐in/near wooded area ☐near a farm ☐exposure to Barns ☐near highway/major roads
   Do you spend time: ☐Gardening ☐camping ☐at a cottage/lake house/second home where?_____
8. Carpet: ☐Wall-to-wall carpeting ☐Carpet in bedroom ☐Rug in bedroom
9. ☐Stuffed toys/throw pillows number_____ how many on bed?_____
10. ☐Feather/down pillow ☐Feather/down comforter ☐Down Jacket
11. Is Cancer screening up to date for age (ex Pap smear, mammogram, Prostate, colonoscopy ect) ☐Yes ☐No ☐N/A
    Any previously abnormal?_____

XI. REVIEW OF SYSTEMS: (Please check any that has been a recurrent or chronic problem for you, **if not already checked above**).

General: ☐fever ☐chills ☐fatigue ☐night sweats ☐weight loss ☐weight gain ☐malaise ☐weakness
Eyes: ☐itchy eyes ☐watery eyes ☐red eyes ☐dry eyes ☐blurred vision ☐double vision ☐vision changes ☐darkness under eyes
Cardiovascular: ☐chest pain ☐increased heart rate ☐palpitations ☐high blood pressure ☐ankle swelling ☐fingers turning blue and painful
Respiratory: ☐wheezing ☐frequent coughing ☐short of breath ☐chest tightness ☐nighttime cough ☐cough with exercise ☐pneumonia
Gastrointestinal: ☐abdominal pain ☐bloating ☐gas ☐heartburn/indigestion ☐constipation ☐nausea/vomiting ☐ diarrhea
GU: ☐urinary retention ☐painful urination ☐increased urinary frequency ☐frequent urination at night
Endocrine: ☐excessive thirst ☐cold intolerance ☐heat intolerance ☐feeling tired/sluggish
Musculoskeletal: ☐joint pain ☐ joint stiffness ☐joint swelling ☐muscle weakness ☐muscle cramps ☐frequent back/neck pain
Integumentary: ☐hives ☐swelling ☐eczema ☐recurrent infections ☐bruise easily ☐skin rash ☐boils ☐persistent itch ☐sun sensitivity
Allergy/Immunology: ☐insect allergy ☐food allergy ☐drug allergy ☐hay fever ☐recurrent infections
Heme/Lymph: ☐swollen glands ☐blood clotting problems ☐bleeding disorders
Neurological: ☐tremors ☐dizziness ☐numbness ☐tingling ☐headache
Psychiatric: ☐depression ☐anxiety ☐behavior problems ☐insomnia

Physician Reviewed_____ Date_____