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PATIENT HISTORY FORM

PATIENT NAME__________________________ **AGE**_______ **SEX**_______ **DATE**_____________

NAME OF PARENT/GUARDIAN____

REFERRED BY____________________________**PRIMARY PHYSICAN**______________________

A. CHIEF COMPLAINTS/REASON FOR TODAY'S VISIT

- List each complaint and when it started.
  1.____
  2.____
  3.____
  4.____
  5.____

B. MEDICATIONS

- List medications that you are currently taking.
  1.________________________Strength______Dose______Frequency_________
  2.________________________Strength______Dose______Frequency_________
  3.________________________Strength______Dose______Frequency_________
  4.________________________Strength______Dose______Frequency_________
  5.________________________Strength______Dose______Frequency_________
  6.________________________Strength______Dose______Frequency_________
  7.________________________Strength______Dose______Frequency_________
  8.________________________Strength______Dose______Frequency_________
  9.________________________Strength______Dose______Frequency_________
  10._______________________Strength______Dose______Frequency_________

- List medication that you have used in the past for allergies or asthma.
  1. Antihistamines____
  2. Nasal Sprays____
  3. Inhalers____
  4. Other____

C. MEDICAL HISTORY

- Check the following medical conditions you are experiencing or have experienced in the past.

__High Blood Pressure	__Nasal Surgery	__Drug Allergy
__Chronic Cough	__Thyroid Disease	__Nasal Polyps
__Frequent Headaches	__Hives	__Seizures
__Heart Disease	__Food Allergy	__Bronchitis

__Sinus Infections __Asthma __Broken Nose
__Hay Fever __Arthritis __Deviated Septum
__Migraine Headaches __Pneumonia __Stomach/Intestinal issues
__Ear Infections __Meningitis __Thrush
__Other____

- Allergy History

-Pollen Allergy Symptoms
(check all that apply)
___Worse outdoors
___Worse on windy Days
___Worse on clear Days
___Worse outdoors in AM
___Worse with change in temperature
___Worse in warm or cool air
___Better indoors
___Better outdoors

-Dust Allergy Symptoms
(Are your symptoms?)
___Worse indoors
___Better outdoors
___Worse at night
___Worse in cold weather
___Worse when sweeping
___Worse when dusting

-Mold Allergy Symptoms
(Are your symptoms?)
___Worse outdoors in PM
___Worse on cool evenings
___Worse in low, damp places
___Worse mowing or playing in grass
___Worse on windy days

-Contact Allergy Symptoms
(Are your symptoms?)
___Worse in certain rooms
-Which rooms_______________
___Worse in basement
___Worse near a barn
___Worse around animals
-Which animals______________

-During what months do you have symptoms:
___Jan ___Feb ___March ___April ___May ___June ___July
___Aug ___Sept ___Oct ___Nov ___Dec

-During what months are your symptoms the most severe:
___Jan ___Feb ___March ___April ___May ___June ___July
___Aug ___Sept ___Oct ___Nov ___Dec

-Are your symptoms constant or intermittent?____________________________

- How many times have an Antibiotic been used in the past year__________________

-Most recent Antibiotic(s)____
-How long was it/they taken____

- Allergies/Intolerances to medications or other substances- Please list name of substance you reacted to, what the reaction was, and when it occurred.

1. ____
2. ____
3.____
4. ____
5. ____
6.____

- List all past surgeries and hospitalizations:
  Date Type of Surgery/Hospitalization Reason
  ____
  ____

D. FAMILY HISTORY

- Circle all relatives with the following conditions
  1. Sinus Disease-- Mother Father Siblings Children
  2. Asthma-- Mother Father Siblings Children
  3. Allergies-- Mother Father Siblings Children
  4. Nasal Polyps-- Mother Father Siblings Children
  5. Eczema-- Mother Father Siblings Children
  6. Immune Problems-- Mother Father Siblings Children

- List any family history of Thyroid problems, Lupus, Rheumatoid, etc.
  ____
  ____
  ____

E. SOCIAL INFORMATION

- Smoking:
  Cigarettes #_____/day Pipe#_____/day Cigars#_____/day
  Years smoked_____ Quit smoking in_____ Second Hand Smoke___Y ___N
- Number of children_____ Marital Status__________ Occupation____________
- If patient is a child, who does he/she live with____________________________
  Are the child's parents married ____ If not, does child live in both homes _____
  Grade in school______ # of days of school missed in last year_____
  If in daycare, # of children in daycare_____
- Home:
  Who lives in your home____
  Pets in the home____
  Type of home: ____House ___ Apartment ___ Slab Foundation ___ Basement
  Heating/Ventilation: ___Forced Air Heat ___ Radiator Heat ___ Central AC
  ___ Wood Burning Stove ___ Ceiling Fans ___ Window AC
  Flooring: ___ Wood
  Which areas of the home_____________________
  ___ Vinyl/Tile
  Which areas of the home_____________________
  ___ Carpet
  Which areas of the home_____________________
  How old is the carpet________________________
  Patient's Bedroom: Are there stuffed animals in the room ___Y ___ N
  Books ___Y___ N Clutter ___Y___N Clothing ___Y ___N

F. SYSTEMS REVIEW/SYMPTOMS (CHECK ALL THAT APPLY)

- General
  ___Weakness ___Change in appetite ___Chills ___Fatigue ___Fever
  ___Night sweats ___Sleep Disturbance

- Eyes
  ___Blurred Vision ___Discharge ___Itching ___Watery ___Redness

- Ears, Nose, and Throat
  ___Nasal Congestion ___Change in sense of smell ___Change in sense of taste
  ___Nasal Itch ___Jaw Pain ___Bad Breath ___Foul taste in mouth
  ___Sore Throat ___Mouth Breather ___Snores ___Hard of hearing
  ___Muffled Hearing ___Ear Fullness ___Ear Pain ___Nasal Discharge
  ___Sneezing ___Ear Itching ___Sinus Pain ___Sinus pressure
  ___Dental Pain

- Endocrine
  ___Hot/Cold Intolerance ___Hair Loss/Gain ___Irregular Menstrual Cycle
  ___Weight Gain ___Weight Loss

- Respiratory
  ___Shortness of Breath at Rest ___Shortness of Breath with exertion ___Shortness of Breath is worse while lying down ___Cough ___Wheeze ___Increased Sputum Production

- Intestinal
  ___Trouble Swallowing ___Constipation ___Diarrhea ___Heartburn ___Nausea
  ___Vomiting

- Skin
  ___Frequent Bruising ___Swelling ___Hives ___Itching ___Rash

- Neurological
  ___Dizziness ___Lightheadedness ___Headaches

- Psychiatric
  ___Anxiety ___Depressed Mood

G. ANY OTHER INFORMATION PERTINENT TO YOUR VISIT

____
____
____
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