rev 07/2020

THE ALLERGY AND ASTHMA CENTER, P.C.

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NAME:_____ AGE:_____ DATE OF BIRTH: _____

APPT. DATE:_____

PRIMARY PHYSICIAN: _____ REFERRING PHYSICIAN: _____

OTHER PHYSICIANS (if you would like records sent): _____

This form should be completed by the patient or parent. Please answer each question as completely and accurately as possible.

CC/HPI 1. What is the **main reason** for this visit _____

_____

2. Please check below if you have frequent **EYE/EAR/NOSE/THROAT** symptoms of:

_____sneezing	_____postnasal drip/drainage in throat	_____itching of eyes
_____congestion (stuffy nose)	_____sore throat	_____red eyes
_____runny nose	_____itching throat	_____puffy eyes
_____sinus infections	_____hoarseness	_____watery eyes
_____itching of nose	_____blocked ears	
_____snoring	_____ear infections	

During which months do you have **EYE/EAR/NOSE/THROAT** symptoms? **Circle** all that apply.

ALL YEAR or Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

3. Please check if you have frequent **SKIN** symptoms of: ____hives/swelling ____eczema ____itching ____other rash

4. Please check if you have frequent **CHEST** symptoms of:

_____shortness of breath	_____productive cough	_____dry cough	_____wheezing
_____nighttime cough	_____chest tightness	_____recurrent bronchitis	_____recurrent pneumonia
_____asthma attacks	_____cough with exercise	_____wheeze with exercise	

During which months do you have **CHEST** symptoms? **Circle** all that apply.

ALL YEAR or Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

5. Have you ever had allergy tests before? _____ If so, where and when were you tested, and what were you allergic to?

_____

_____

6. Have you ever been on allergy shots or drops? _____ If so, from age _____ to _____ Did they help? _____

7. Have you ever been hospitalized or admitted to the emergency room for asthma, allergy, or infection? _____

8. Have you ever had sinus surgery (if so, when/where)? _____ Did it help? _____

9. Have you ever had an allergic reaction to a food? If so, please identify food and describe the reaction: _____

_____

_____

10. Have you ever had a severe allergic reaction to an insect sting or bite? _____

_____

Patient_____

11. What type of medicines have you used for allergy/asthma/sinus problems? Please **CIRCLE ALL** that you have tried below.

Antihistamines:	Claritin (loratadine), Clarinex (desloratadine), Allegra(fexofenadine), Zyrtec (cetirizine), Xyzal (levo-cetirizine), Benadryl, other over the counter
Decongestants:	Sudafed/pseudoephedrine, phenylephrine, other "D" products
Nasal Steroids:	Flonase(fluticasone), Nasacort (triamcinolone), Nasonex, Omnaris, QNasl, Rhinocort, VeraMyst, Zetonna
Other Nose Spray:	Astelin/Astepro (azelastine), Patanase, Dymista, Afrin, Atrovent
Antibiotics	
Leukotriene Blockers:	Singulair (montelukast), Accolate (zafirlukast), Zyflo
Inhaled steroids	Flovent, Pulmicort/budesonide, Alvesco, Asmanex, Azmacort, QVAR, Arnuity, Aerospan
or combination inhalers:	Advair, Dulera, Symbicort, Breo
Relief inhalers:	albuterol, Xopenex, Proventil, ProAir, Ventolin, Maxair, Combivent, Atrovent
Other inhalers:	Serevent, Foradil, Spiriva, Arcapta, Anoro, Brovana, Perforomist, cromolyn, Tudorza
Steroids (oral or shots):	prednisone, Orapred, Pediapred, Prelone, cortisone, Medrol, methylprednisolone

12. How many days of work or school have you missed in the last year for reasons of allergy, asthma, or sinusitis? _____

13. Do you have acid reflux or frequent heartburn/indigestion? _____ Do you take medicine for it? _____

ID

14. Do you have a history of frequent infections? _____ If yes, please circle below which types of infections you have had:
sinusitis, bronchitis, pneumonia, gastroenteritis, chronic diarrhea, Giardia, ear infections, meningitis, osteomyelitis, severe skin infections, abscesses, fungal infections, parasites or worms, sepsis or bloodstream infection

15. Have you ever been diagnosed with an immune deficiency, AIDS, or HIV? _____

PMHx

16. Please indicate if **the patient** has been **diagnosed with** any of the following conditions, current or past.

PSHx

Allergy:	hay fever/rhinitis, asthma, atopic dermatitis, food allergies, urticaria (hives), angioedema
HEENT:	migraines, severe head injury, glaucoma, cataracts, other eye disease, deafness
Cardiovascular:	high blood pressure, heart disease, heart murmur, heart attack, pacemaker, angina, heart valve problems, arrhythmias
Respiratory:	asthma, COPD, emphysema, pneumonia, chronic bronchitis, other lung disease
Gastrointestinal:	acid reflux/heartburn, ulcers, eosinophilic esophagitis, liver disease, hepatitis, gallstones irritable bowel syndrome, Crohn's disease, ulcerative colitis, diverticulitis
Genitourinary:	kidney disease, kidney stones, interstitial cystitis, prostate enlargement, prostate cancer
Rheum:	rheumatoid arthritis, osteoarthritis, gout, other arthritis, lupus, scleroderma, connective tissue disease
Neuro/psych:	epilepsy/seizures, depression, anxiety, other psychiatric/nerve problems
Endocrine:	hypothyroid, hyperthyroid, diabetes
Blood:	anemia, hemophilia or bleeding disorder, sickle cell disease, past blood transfusions, leukemia
Cancer:	_____
Other:	_____

17. Please indicate the reason for **ALL past hospitalizations and surgeries** and patient's age or year at the time.

Age or Year	**Reason for hospitalization or type of surgery**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

MEDS 18. Please **LIST ALL MEDICATIONS** that you take currently. Include prescriptions, over-the-counter medicines, supplements etc.

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

MED ALLG **19**. Are you **allergic to any medicines?** (please list)

Med: _____ Reaction: _____

Med: _____ Reaction: _____

Med: _____ Reaction: _____

Med: _____ Reaction: _____

Med: _____ Reaction: _____

EFSHx 20**. Family History**

Patient's Father: ____living ____deceased current age if alive _____ or age at death _____

If deceased, died of _____

significant health issues _____

Patient's Mother: ____living ____deceased current age if alive _____ or age at death _____

If deceased, died of _____

significant health issues _____

Patient's Siblings: ages of living siblings _____

cause of death and age at death of any deceased siblings _____

significant health issues _____

Patient's Children: ages of living children_____

cause of death and age at death of any deceased children_____

significant health issues _____

Please indicate which, if any, immediate family members (parents, siblings, or children) have been diagnosed with the following:

Asthma _____

Allergies_____

Hereditary angioedema or hereditary forms of hives _____

Sinus problems_____

Immune Deficiency_____

Cancer_____

Diabetes_____

Coronary artery/heart disease/heart attack_____

High blood pressure/hypertension_____

Autoimmune Diseases (e.g. lupus)_____

Arthritis_____

Other_____

21. Please provide the following information about the living **environment:**

Home is a: House—Apartment—Townhouse—Farm---Mobile home How old is the home? _____ years

Location of home: Murfreesboro Smyrna Brentwood Other _____

Is the patient's bedroom carpeted? _____ If yes, how old is the carpet? _____yrs

Mattress _____ years old Pillow _____ years old Is there a mold or mildew problem in the home? _____

Patient Smoking History: never smoked current smoker quit (when)_____

Any smokers in the home? _____

Any indoor pets? _____ What kind of pets are indoors? _____

Do the pets stay in the patient's bedroom? _____

Where does the patient work or go to school, if applicable? _____

Are there any unusual hobbies, or other work or environmental exposures? _____

_____

ROS 22. Please note if the **patient** has a history of significant problems in the following areas. (**Circle** positives.)

General:	weight change, weakness, fatigue, obesity
HEENT:	headaches, dizziness, ringing in the ears, hearing loss, ear tubes, eye diseases
Neck:	lumps in neck, swollen glands, goiter, neck pain
Cardiovascular:	chest pain, swollen feet, palpitations, blood clots in legs, varicose veins
Gastrointestinal:	trouble swallowing, heartburn, nausea/vomiting, vomiting blood, indigestion, constipation, diarrhea, rectal bleeding, black tarry stools, abdominal pain, food intolerance, jaundice
Genitourinary:	frequent urination, excessive urine production, nighttime urination, pain on urination, blood in the urine, urinary infections, incontinence
Rheum:	joint pain, backaches, muscle pains, muscle cramps, arthritis
Neuro/psych:	fainting, blackouts, paralysis, numbness, tingling, tremors, memory loss, nervousness, tension, excessive mood swings
Endocrine:	excessive sweating, excessive thirst or hunger, intolerance of heat or cold, other hormonal problems
Blood:	easy bruising, easy bleeding
Other:	_____

23**.** **SPACE FOR ADDITIONAL COMMENTS** _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Reviewed with patient by (physician initials): _____