Allergy, Asthma, & Sinus Center

New Patient Visit

Name	Today's date	Age	Sex (circle one) M F

Chief Complaint: (check all that apply)

	Rashes		Mouth breathing
	Hives		Nasal congestion
	Eczema		Runny nose
	Vomiting		Yellow-green nasal drainage
	Diarrhea		Sinus headaches/infection
	Joint pain		Itchy watery eyes
	Fever		Bee sting reaction
	Snoring		Food or drug reaction
	Sneezing		Shortness of breath with exercise
	Coughing		Wheezing or chest tightness

Diagnosis of asthma made ____________ yrs ago.
# of hospitalizations for asthma: ____________
# of ER visits for asthma: ____________
# of missed work/school days in past year: ___

Frequent infections:
# of ear infections in past year: ____________
# of pneumonia infections in lifetime: ________
# of sinus infections in past year: ____________

Other (explain): ________________________

These symptoms occur: (circle all that apply)

Spring Summer Fall Winter All the time

These symptoms are worse: (circle all that apply)

Outdoors Indoors Work School Morning

Night All day Rainy Cold Hot Pets

How long have you suffered from these symptoms?

	Y	N
Any previous allergy testing?		
Previous allergy shots?		
Still on allergy shots?		
Shots received every ________ weeks.		
Any reaction other than minor local?		
Do you have a peak flow meter at home?		
How often do you check peak flow?		
Do you have a spacer for your inhaler?		
Do you use the spacer?		
Date of last chest x-ray:		

Medications:

Medication	Current		Helpful		Dosage	Frequency
	Y	N	Y	N		

Healthcare provider's note taking space.

Past Medical History:

Hospitalization	Age	Year	For

Surgeries	Age	Year	For

Drug allergy	Reaction

Are your immunizations up to date? Yes No

Other chronic health conditions:

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Family History: (father, mother, sibling, grandparent)
[circle all that apply and indicate who had which ailment]

Asthma	Hives
Eczema	Bronchitis
Tuberculosis	Hypertension
Cystic fibrosis	Liver disease
Arthritis	Cancer
Endocrine/ Gland disease	Frequent infections
Hay Fever	Emphysema
Sinus infections	Heart disease
Diabetes	Infant deaths

Social History: (circle all that apply)
What environment do you currently live in?
House Apartment Trailer Rural Urban
Occupation:______________________________
Marital status: (circle one) S M D W

	Y	N		Y	N
Live in basement			Cigarette smoke		
Plastic covered mattress			Forced air heat		
Plastic covered pillow			A/C		
Feather pillow			Change filters		
Down bedding			Pet		
Carpet/rugs			Fan/humidifier		
House plants			Stuffed toys		
Cockroaches			Windows closed		

Type of window treatment: (circle all that apply)
blinds curtains shades

Smoke: (circle one) Y N Quit__________yrs ago
How many packs do you smoke per day?__________
Exercise regular: (circle one) Y N Type__________
Lives with ______________________

Review of Systems: (check all that *apply to you*)

	Weight change		Sore throat
	Appetite change		Chest pain
	Activity change		Leg cramps
	Voice change		Nausea
	Smell change		Constipation
	Fatigue		Frequent urination
	Blurred vision		Bladder infections
	Red eyes		Change in periods
	Eye swelling		Itching
	Eye infections		Bruising
	Nose bleeds		Bleeding
	Post nasal drip		Change in sensation
	Dizzy		Depression
	Mouth ulcers		Sleep problems
	Ear infections		Constant thirst
	Ear pain		Swollen glands
	Ear popping		Feel hot/cold
	Throat infections		Other:

Healthcare provider's note taking space.

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