Revised 4/10/2017

Asthma and Allergy Clinic, P.A.
Medical History

Last Name: _____ **First Name**:_____ **M.I.** ____ **Date of Birth:** _____

Referring Physician:_____ **Date of visit:**_____

Past and Current Illnesses Circle if the patient currently has or has had in the past:

Hay fever	Adverse Drug Reaction	Arthritis	Stomach Problems
Asthma	Chronic Bronchitis	Diabetes	HIV/AIDS
Hives	Tuberculosis	Epilepsy	Glaucoma
Atopic Dermatitis	Anemia	Chronic Headache	Cataracts
Chronic Sinus Problems	Hypertension	Kidney Disease	Thyroid Disease
Nasal Polyps	Stroke	Liver Disease	Pneumonia
Insect Sting Allergy	Heart Disease	Cancer	Depression
Other:	Other:		

Hospital HIstory:

Hospitalizations and Surgeries:	**Reason?**

Current Medications:
List all medications that you currently take (include over the counter preparations, vitamins and supplements):

MEDICATION NAME	Amount	Times Taken per Day	For what reason do you take it?

*** additional medications that you currently take (include over the counter preparations, vitamins and supplement**s) write or back of this form or **attach a separate sheet of paper**

Reactions:
List all medications you do not tolerate:

MEDICATION	REACTION	DATE

List all foods you do not tolerate:

FOOD	REACTION	DATE

Name:_____ **DOB:**_____

Family Medical History: Check if there is any history in your family?

Family History Follow lines across the page. Mark appropriate box.	Alive & Well	Deceased	Age of Death	Cause of Death	Hayfever	Asthma	Nasal Polyps	COPD	Cystic Fibrosis	High Blood Pressure	Diabetes	Recurrent Infections	Cancer	Other	Other	Other
Mother																
Father																
Brother																
Sister																
Other:																

* Please use reverse side for additional information.

SOCIAL HISTORY

Relationship Status: □Married □Single □ Widowed □Divorced □Partnered Number of other people living in home:

Occupation: Do the symptoms improve or worsen at work?

Explain:

List hobbies and recreational activities:

Smoking Status: □Current every day smoker □Current sometimes smoker □Former smoker □Never Smoke

□Cigarettes □Cigars □e-cigarettes _____mg or vapors _____mg □Pipe □Smokeless tobacco Age started:_____
Amount used daily:_____
Quit Date:_____

On a Scale of 0 - 10, where is definitely not important/ not ready to quit using tobacco and 10 is definitely important/ready to quit, what number best reflects how ready you are to quit. 0 1 2 3 4 5 6 7 8 9 10

Alcohol □Yes □No What type:_____ Amount per day_____ per week_____ per month_____

Recreational Drugs: □Yes □No What type: _____ Amount per day_____ per week_____ per month_____

Environmental Survey:

Any recent water damage in home? □Yes □No Problems with □cockroaches □mice □other pest
Are there any smokers who live with this patient? □Yes □No Do they smoke in the home? □Yes □No
Are there any pets? □Yes □No How many pets _____ What type of pets:_____

Review of Systems: Circle any of the following that apply

CONSTITUTIONAL SYMPTOMS: fever weight loss extreme fatigue
EYES: sudden loss of vision pain redness excessive tearing double vision
EARS, NOSE, MOUTH AND THROAT: sore throat runny nose ear pain
RESPIRATORY: cough shortness of breath wheezing
CARDIOVASCULAR: murmurs chest pain palpitations
GASTROINTESTINAL: Trouble swallowing heartburn nausea/vomiting abdominal pain constipation diarrhea blood in stools
SKIN: rashes itching dryness changing mole
NEUROLOGICAL: headache persistent weakness or numbness on one side of the body falling
PSYCHIATRIC: depression anxiety suicidal thoughts
GENITOUTINARY: irregular menses vaginal bleeding after menopause frequent or painful urination bloody urine impotence
MUSCULOSKELETAL: join pain muscle weakness
Endocrine: excessive thirst cold or heat intolerance breast mass
Hematologic: unusual bruising or bleeding enlarged lymph nodes
Allergic: hay fever Asthma hives anaphylaxis