Please answer **all** questions on the following **three** pages to the best of your ability.

1.) Briefly describe the problem(s) which have caused you to see the doctor today.

2.) Have you ever been hospitalized or seen in the emergency room for this/these problem(s)? Yes___ No___
(If yes, state when.)

3.) Do your symptoms ever awaken you at night? Yes_____ No_____ If yes, how often?_____

4.) Are your symptoms triggered or worsened by exposure to any of the following **allergens**? (circle)

Dust Pollens Cats Dogs Mold (raking leaves, hay rides, damp basements etc..) Other _____

5.) Are your symptoms triggered or worsened by exposure to any of the following **irritants**? (circle)

Smoke Perfumes Strong Odors Cold Air Exercise Other _____

6.) Please list other factors which you feel are associated with triggering your symptoms. _____

_____

7.) Please list the names of **all** medications you are currently taking, including over the counter medications, vitamins, health supplements. _____

_____

8.) Please list any drug allergies _____

9.) Other physicians you have seen for this/ these problems: _____ _____
_____ _____

Past Medical History

Childhood: (Circle) Infections: ears, throat, sinuses, chicken pox, measles, mumps, Other _____

Have you ever been **diagnosed** with any of the following ? (Please check **Yes** or **No**)

	YES	NO	Physician Comments
Asthma	____	____	
AHay Fever@/ Allergic Rhinitis	____	____	
Eczema/ Dermatitis	____	____	
Sinus Problems	____	____	
Chronic Bronchitis	____	____	
Emphysema/ COPD	____	____	
Pneumonia/ Pleurisy	____	____	
Infectious Mononucleosis (AMono@)	____	____	
Heart Disease/ Angina	____	____	
High Blood Pressure	____	____	
Cancer (Type:_____)	____	____	
Thyroid Disorder (over or under active)	____	____	
Diabetes	____	____	
Liver disease or Hepatitis	____	____	
Ulcer (Stomach or Duodenal)	____	____	
Kidney disease	____	____	
Colitis	____	____	
Rheumatic Fever	____	____	
Arthritis (Joint Pain or Stiffness)	____	____	
Other_____			

Reviewed By _____ M.D

What surgeries have you had? (Please include tonsils/ adenoids):

Any problems with anesthetics? YES NO Any blood transfusions? YES NO

Have you received the following immunizations?

1) Influenza (Yearly Flu Shot)	**YES**	**NO**	**Unsure**
2) Tetanus (within last 10 years)	**YES**	**NO**	**Unsure**
3) Pneumonia shot (Pneumovax)	**YES**	**NO**	**Unsure**

SMOKERS IN HOME: No **Yes** (who?)

Occupational History

What is your current occupation?_____

How many days of work (school) missed per year due to illness? _____

Are you exposed to any of the following at work (school)? (circle)

Smokers Animals Vapors/gasses Dust Chemical sprays Other irritants_____

Social History

Smoking/Tobacco:

Current smoker: Yes_____ No _____
packs/day _____
age started _____
age stopped _____

Marital Status: Single _____Married ____
Widowed_____ Divorced_____
Number of Children _____

Did you grow up in a home with smokers? ___Yes ___No

Place of Birth_____
Other states/countries you have lived in:

Alcohol Use: Never_____ Occasional _____
Frequent (daily)_____

Have you travelled outside the USA in the last 5 years: YES NO

Caffeine: No__ Yes__ (how much?)_____

Have become ill on your travels outside the USA: YES NO

Hobbies/Exercise:

Family History: Please **check** all that apply to members of your family.

	Mother	Father	Siblings	Children	Other Relative	Physician Comment
Allergic Rhinitis (Hay Fever)	_____	_____	_____	_____	_____	
Asthma	_____	_____	_____	_____	_____	
Sinus Problems	_____	_____	_____	_____	_____	
Hives/ Swelling	_____	_____	_____	_____	_____	
Eczema/ Dermatitis	_____	_____	_____	_____	_____	
Drug Allergy	_____	_____	_____	_____	_____	
Food Allergy	_____	_____	_____	_____	_____	
Food Allergy	_____	_____	_____	_____	_____	
Stinging Insect Allergy..	_____	_____	_____	_____	_____	
Emphysema/ COPD ..	_____	_____	_____	_____	_____	
Chronic Bronchitis	_____	_____	_____	_____	_____	
High Blood Pressure	_____	_____	_____	_____	_____	
Heart Disease	_____	_____	_____	_____	_____	
Diabetes	_____	_____	_____	_____	_____	
Thyroid disorder ……..	_____	_____	_____	_____	_____	
Cancer	_____	_____	_____	_____	_____	
SLE/RA.....	_____	_____	_____	_____	_____	

Reviewed By _____ M.D

Review of Systems:

Please **circle** any of the symptoms which you are **currently experiencing** or which have caused you **serious** problems in the past:

General: fever, night sweats, weight changes, fatigue, loss of appetite

Eyes: itching, tearing, redness, dry, swelling, discharge, contact lenses, cataracts, glaucoma

Ears: ear fullness, popping, itching, loss of hearing, ringing, infection

Nose: sneezing, itching, runny nose, stuffy/congested, discharge , loss of smell bloody nose

Throat: sore throat, post nasal drip, itchy palate, oral ulcers

Lymph glands: glandular swelling, glandular tenderness cancer (lymphoma)

Chest: wheezing, cough, short of breath, chest pain, palpitations
bronchitis, pneumonia, asthma, coughing up blood

Intestinal Tract: nausea, vomiting, heartburn, trouble swallowing, cancer

stomach pain, constipation, diarrhea, excessive gas

Urinary: urinary infections, frequent urination, prostate problems, kidney stones cancer

Rheumatologic: joint stiffness, joint swelling, joint pain, osteoporosis, fractured bones

Skin: rash, hives, welts, itching, eczema, cancers, hair loss,
fingers turn white in cold temperatures (Raynauds)

Neurologic: black outs, severe headaches, epilepsy (seizures), inability to concentrate,
trouble sleeping , numbness, sciatica

Hematologic: low blood count (anemia) low platelet count easy bleeding blood clots cancer (leukemia)

Endocrine: heat intolerance, cold intolerance, diabetes, thyroid disease thyroid cancer

Female History irregular periods, breast disease breast cancer
Are you or could you be pregnant now? YES NO
Have you been on birth control pills within the last year? YES NO

All Others Neg._____

Reviewed By: _____ MD