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.) Which time of day are your symptoms worse? (circle) Morning Afternoon Evening Nighttime

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

5.) Are your symptoms worse during certain seasons? Yes____ No____

If yes, which season? (circle) Winter Spring Summer Fall

7.) 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 __________

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

Smoke Perfumes Strong Odors Cold Air Exercise Other ____________________

9.) Please list other factors which you feel are associated with triggering your symptoms. ____________________

10.) Please list the names of **all** medications you are currently taking, including "over the counter" ________________
____

11.) Please list any drug allergies ____

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	____	____	
"Hay Fever"/ Allergic Rhinitis	____	____	
Eczema/ Dermatitis	____	____	
Sinus Problems	____	____	
Chronic Bronchitis	____	____	
Emphysema/ COPD	____	____	
Pneumonia/ Pleurisy	____	____	
Infectious Mononucleosis ("Mono")	____	____	
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____

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?

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

Reviewed By ________ M.D.

ENVIRONMENTAL SURVEY
Please **check** or **complete** the answers to describe your home.

Type of Home: House____ Apartment____ Other_____________

Approximate age of home: _____ years Years of occupancy_____

Location: City____ Suburban____ Country____

Near your home is there a: Barn___ Prairie___ Factory____ Other________

Obvious mold/mildew? Yes / No Lots of dust? Yes / No Roaches? Yes / No

Heating System: Forced Air___ Radiator___ Baseboard___ Other_____________

Air Conditioning: Central___ Window units___ Fans___ How often do you change the air filter ?_______

In the spring / summer / fall windows are primarily kept: Open ____ Closed ____

Floor coverings: Carpet___ Area rug___ Wood___ Other_____

Is there a basement or crawl space? Yes___ No ___

Is the basement damp or musty? Yes___ No ___
If yes, do you spend much time in the basement? ___Yes ___No

BEDROOM
Located in : Basement___ First Floor___ Second Floor___ Attic___

Floor Covering Carpet___ Area rug ___ Wood___ Other__________

Bed mattress: Conventional___ Futon ___ Water___

Pillows: Synthetic/Foam____ Feather/Down_____

Comforter: Cotton/Synthetic _____ Feather/Down _____ Wool ____

Household Pets: Cat_____ Dog_____ Bird_____ Other__________
Do they go into the bedroom? Yes___ No___

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 ____
Former Smoker: Yes ____ No ____
packs/day _______
age started _______
age stopped _______
Vaping/e-cigs/Other (explain) ____________

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 you have lived in:

Alcohol Use: Rare/Never_____ Occasional _____ Frequent (daily)______
Caffeine: No__ Yes__ (how much?)___________
Hobbies/Exercise: ___________________________

Reviewed By ________ M.D.

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	______	______	______	______	______	
Stinging Insect Allergy	______	______	______	______	______	
Emphysema/ COPD	______	______	______	______	______	
Chronic Bronchitis	______	______	______	______	______	
High Blood Pressure	______	______	______	______	______	
Heart Disease	______	______	______	______	______	
Diabetes	______	______	______	______	______	
Thyroid disorder	______	______	______	______	______	
Cancer	______	______	______	______	______	
Other _______________	______	______	______	______	______	

Review of Systems:

Please **circle** any of the following 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

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

Throat: sore throat, post nasal drip, itchy palate

Lymph glands: glandular swelling, glandular tenderness

Chest: wheezing, cough, short of breath, chest pain, palpitations

Intestinal Tract: nausea, vomiting, heartburn, trouble swallowing,
stomach pain, constipation, diarrhea, excessive gas

Urinary: urinary infections, frequent urination, prostate problems

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

Skin: rash, hives, welts, itching, eczema, cancers, hair loss

Neurologic: black outs, severe headaches, epilepsy (seizures), inability to concentrate,
trouble sleeping , early morning awakening

Endocrine: heat intolerance, cold intolerance

Female History irregular periods, breast disease
Are you or could you be pregnant now? YES NO

Have you been on birth control pills within the last year? YES NO

Reviewed By ________ M.D.