

PATIENT NAME: _____ (Adult) DATE _____ D.O.B. _____

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	<u>Physician Comments</u>
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.

PATIENT NAME: _____ (Adult) DATE _____ D.O.B. _____

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 _____

Marital Status: Single ____ Married ____

Widowed____Divorced_____

Number of Children _____

Vaping/e-cigs/Other (explain) _____

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: _____

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

	<u>Mother</u>	<u>Father</u>	<u>Siblings</u>	<u>Children</u>	<u>Other Relative</u>	<u>Physician Comment</u>
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

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