Northeast Georgia PHYSICIANS GROUP

Allery and Asthma

Patient History Form Date:_____

Patient Name:_____Primary Physician:_____
Age:_____DOB:_____Who Referred you to us?_____
Main reason you are here:_____

On all sections; please circle any symptoms you are having or have had.

○ Nasal / Sinus Symptoms

How long have you had nasal or sinus symptoms?_____weeks_____months_____years
Nasal congestion
Runny nose: Yes / No
If yes, what is the color? _____
Sneezing: Yes / No
Please circle your worst season(s)? Spring Summer Fall Winter Year-round
Itchy nose: Yes / No Throat: Yes /No or Ears: Yes /No
Itchy watery eyes: Yes /No
Postnasal sinus drainage: Yes / No If yes, what is the color if any _____
Sinus headaches: Yes / No If yes, where _____
Nosebleeds: Yes / No
Bad breath or bad taste in mouth: Yes /No occasionally___frequently__constantly____
Sinus infections: Yes / No If yes, how often? _____
Popping in ears: Yes / No Yes /No occasionally___ frequently_____ constantly____
Have you had any sinus x-rays or CT scans? Yes / No; if Yes, when and what were results?
_____
Medicines tried Yes / No if yes, did they help?_____
Your symptoms worsened by what?_____
Have you been seen by an Allergist in the past? Yes /No if yes, when and what were the results)__
_____

○ Chest and Lungs

When did your chest or lung symptoms first start? _____
Did you experience any of the below with the first onset? _____
Shortness of breath Yes /No; If No, when did you first experience? _____
Chest tightness Yes /No; If No, when did you first experience? _____
"Rattles" in chest Yes /No; If No, when did you first experience? _____
Wheezing Yes /No; If No, when did you first experience? _____
Cough, if Yes; is cough worse at day, at night or both? _____
Sputum coughed up, Yes / No; if Yes, color: _____

Are chest symptoms worsened by (circle all that apply) viruses, cigarette smoke, exercise / running, temperature changes, weather changes, strong odors, chemicals, laughter, or emotional upset?

Have you ever been diagnosed with asthma? Yes / No; if Yes, when?_____

Do these symptoms awaken you at night or keep you from sleeping? Yes / No; if Yes, how often?_____

Do symptoms limit your daily activities? Yes / No if Yes, how?_____
Do symptoms limit your exercise? Yes / No if Yes, how?_____
Have you ever been hospitalized for chest and lung symptoms? Yes / No if Yes,
How many times?_____Last time?_____
Have you been treated in the ER for these symptoms? Yes / No if Yes,
How many times?_____Last time?_____
Are there any medicines that you have tried, other than what you are currently on, for these symptoms?

○ Stomach

Do you have heartburn? Yes / No
Frequent burping? Yes / No; if Yes, how often?_____
Do you have chronic diarrhea? Yes / No
If a child, has growth been normal? Yes / No

○ Other Allergies

Eczema: Yes / No; if Yes, please explain:_____

Hives: Yes / No; if Yes, please explain:_____

Other rashes: Yes / No; if Yes, please explain:_____

Reaction to Foods: Yes / No; if Yes, please list the food(s) and the reaction:_____

Reaction to Medicine: Yes / No; if Yes, please list the medicine and the reaction:_____

Reaction to Insects: Yes / No; if Yes, please list the insect and the reaction:_____

○ Past Medical History

Do you have any long-term medical problems? Yes / No; if Yes, please explain:_____

Have you ever had surgery? Yes / No; if Yes, please list the surgery and when:_____

Any hospitalizations? Yes / No; if Yes, please list what hospitalizations was for and when:_____

Please list **All medications currently taking, including over the counter medication and how often taken:

Are your immunizations up to date? Yes / No

Patient Name:_____ DOB:_____

○ Environmental History

How long have you lived at your current home? _____

Is it a house, apartment, mobile home? How old?_____

It is made of: brick, wood, siding, block, other:_____

Type of bed mattress: (circle all that apply) foam, inner spring, waterbed

Type of pillow: foam, feather, other:_____

Floors are: (circle all that apply) carpet, wood, linoleum, tile, other:_____

Air conditioning: (circle all that apply) none, window unit, central

Heat: (circle all that apply) electric, gas, wood, oil, kerosene Basement: none, dry, damp, very wet

Heat / air filters changed every_____month

Any pets? Yes / No; if Yes, please list below:

Indoor pets_____Outdoor pets_____

Any smokers living there? Yes / No; if Yes, Who?_____Smokes indoors or outdoors?

How many people live there?_____

Anything unusual or remarkable about this home? If Yes, please explain:_____

_____

○ Family History

List all allergies, asthma, eczema and related problems such as sinus problems:

Father: Yes, No N/A If Yes, please explain:_____

_____

Mother: Yes, No N/A If Yes, please explain:_____

_____

Brother: Yes, No N/A If Yes, please explain:_____

_____

Sister: Yes, No N/A If Yes, please explain:_____

_____

Sons: Yes, No N/A If Yes, please explain:_____

_____

Daughters: Yes, No N/A If Yes, please explain:_____

_____

○ Social History

Occupation (if retired, previous work):_____

Work environment:_____

If student, what school and grade?_____

Tobacco use: None, Smoking Now, or Quit in _____

If you ever smoked, how many packs per day ___ for how many years__.

What are your hobbies:_____

Ais there anything else you would like to discuss?