Northeast Georgia PHYSICIANS GROUP
Allergy & 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 ____ occasionally ____ frequently ____ constantly___

Have you had any sinus x-rays or CT scans? Yes / No If yes, when and what were the 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 you chest or long 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: Yes / No If yes, is cough worse at day, at night or both? _____

Sputum coughed up: Yes / No If yes, what 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? _____

Patient Name: _____ DOB: _____

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(s) and the reaction:_____

_____

Reaction to Insects: Yes / No; if yes, please list the insect(s) 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 were 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? _____

Is it 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 _____ months

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 on _____

If you ever smoked, how many packs per day _____ for how many years _____

What are your hobbies: _____

Is there anything else you'd like to discuss? _____