Allergy & Asthma Center, P.C.

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Patient Name			
Date of Birth		**Date**	

Briefly describe reason for allergy visit:____

____

____

Have you ever had the following conditions? (Write YES or NO for each item):

	Present problem	Past problem	Age at onset	Mild: 1-2 days/week	Moderate: 2-5 days/week	Severe: 5+ days/week
Runny nose or itchy nose						
Sneezing						
Itchy eyes						
Stuffy or congested nose						
Sinus problems						
Wheezing						
Persistent coughing						
Chest tightness						
Shortness of breath						
Bronchitis or prolonged coughing with "colds"						
Pneumonia						
Emergency room visit or hospitalization for breathing problems						

Check any symptoms that occur after vigorous exertion or exercise:
☐ coughing ☐ wheezing ☐ chest tightness ☐ throat clearing

Are your symptoms worse during certain months of the year? ☐ Yes ☐ No
Which months?____
If yes, do you have mild symptoms year around? ☐ Yes ☐ No, am well rest of the year

Check any conditions that make your symptoms worse:
☐ mowing the lawn, exposure to cut grass, playing in grass
☐ sweeping, dusting, using vacuum cleaner
☐ tobacco smoke or other fumes
☐ moldy or mildewed areas
☐ raking leaves
☐ being around animals or the places where animals live
☐ strong odors or perfumes
☐ other (specify below)
Specify:____

BEE STING (honey bee, yellow jacket, hornet, wasp):
Date of sting(s)____
I had the following reaction: ☐ large local swelling around the sting only ☐ trouble breathing
☐ hives or swelling on other parts of my body ☐ vomiting ☐ feeling faint

FOOD REACTION:
I have had reactions to the following food(s): ☐ milk ☐ eggs ☐ fish ☐ peanut ☐ nuts
☐ other (specify)____
I get the following symptoms from these foods: ☐ stomachache ☐ loose bowels (diarrhea) ☐ nausea
☐ rash ☐ stuffy nose ☐ asthma ☐ other (specify)____

Patient's Name____**Birthdate**____/____/____

ENVIRONMENTAL HISTORY:

Geographic history:

Where were you born?____

In what state (country) did you spend most of your life?____

How long have you lived in Oregon?____

Home environment:

Type of heating:____

How old is your mattress?__________________pillow?______________check if waterbed________________

☐ Yes ☐ No Is your pillow covered with zip-on hypoallergenic covers? ☐ Yes ☐ No Synthetic

☐ Yes ☐ No Do you have a feather comforter?

☐ Yes ☐ No Is there carpeting in your bedroom? How old is it?_____________

☐ Yes ☐ No Does your house have dampness, mold, or mildew problems?

How old is your home?____________ How long have you lived there?____________

Is it an apartment?____________ Is it a manufactured home?____________

How many pets come inside your home (specify number)?

__________dogs __________cats __________other (specify) ________________________________

☐ Yes ☐ No Do you have horses or other outside animals?

Specify:____

Lifestyle history:

☐ Yes ☐No Have you ever smoked or vaped? Date quit____

☐ Yes ☐No Do you presently smoke or vaped?

How many years have you or did you smoke or vape? ____

How many packs (average) per day?____

☐ Yes ☐ No Does anyone else in the home smoke or vape? Who?

☐ Yes ☐ No Do you use alcohol? How much/how often?____

☐ Yes ☐ No Do you use recreational drugs? What?____

☐ Yes ☐ No Do you have an Advance Directive?

Occupational history:

What type of work do you do?____

Do you use over-the-counter nose sprays? ☐ Yes ☐ No ☐ Occasionally ☐ Regularly

Have you ever received a corticosteroid (cortisone) injection for allergies? ☐ Yes ☐ No

Have you had sinus surgery? ☐ Yes ☐ No Date____

Date of last chest x-ray:________________________ Date of last sinus CAT scan:________________________

Review of Systems: Have you ever had any of the following? Circle or check all that apply:

Frequent headaches
Ear infections/Sinus infections
Glaucoma/Cataracts
Heart trouble
Psychiatric
High blood pressure
Thyroid problems
Skin problems
Tuberculosis
Diabetes
Stomach or digestive problems
Kidney trouble
Liver trouble
Neurological problems

Family Health:

☐ Yes ☐ No Is there a history of allergy in your family? If yes, please indicate:

	Allergies	Hay fever	Asthma	Sinus problems	Eczema	Hives
Parents						
Siblings						