NAME ____M____F____ AGE __________ TODAY'S DATE___________

PRIMARY PHYSICIAN ____ REFERRING PHYSICIAN__________________________

HAVE YOU EVER BEEN DIAGNOSED WITH? ASTHMA — REACTIVE AIRWAY – HAY FEVER — SINUS PROBLEMS — SINUSITIS – RECURRENT INFECTION –- CHRONIC BRONCHITIS — EMPHYSEMA — COPD –- ECZEMA — HIVES — WEAK IMMUNE SYSTEM – FOOD ALLERGY – CAN YOU TAKE ASPIRIN OR MOTRIN? ______ CAN YOU TAKE PENICILLIN?_______

LIST ALL DRUG REACTIONS? (LIST DRUGS AND TYPE OF REACTION) ____

ALLERGIC REACTIONS TO INSECTS? (LIST INSECTS AND DESCRIBE)____

REACTIONS TO FOODS? (LIST FOODS & DESCRIBE)____

REASON FOR TODAY'S VISIT ____

SYMPTOMS (Circle all that apply)
RUNNY NOSE (COLOR) ________
STUFFY NOSE, SNORING
DECREASED SENSE OF SMELL
ITCHY NOSE, ITCHY EYES, DRY EYES
SNEEZING, POST NASAL DRIP
BLOCKED EARS, EARACHE
SINUS PAIN, HEADACHE, DIZZINESS
SORE THROAT, HOARSENESS

PNEUMONIA (HOW MANY) ___
BRONCHITIS ______
EAR INFECTIONS ______
SINUS INFECTIONS ______
COUGHING (FREQUENT /RARE)
WHEEZING
WHEEZING AT NIGHT
SHORTNESS OF BREATH
COUGH AFTER EXERCISE
CHEST TIGHTNESS

HIVES________________________
ECZEMA________________________
OTHER RASH________________________
OTHER SYMPTOMS ________________________
RECENT CHEST X RAY? ___ RESULTS: ____________
CT SCAN OF SINUS OR CHEST?___ RESULTS: _____
WORST SEASON________________________
BEST SEASON________________________
ARE SYMPTOMS YEAR ROUND? __________________

FOR HOW LONG HAVE YOU HAD THESE PROBLEMS? ________________ ARE SYMPTOMS GETTING BETTER OR WORSE?_____

WHAT MAKES YOUR SYMPTOMS WORSE? ____

IS YOUR CONDITION WORSE: AT WORK? — AT HOME? — INDOORS? — OUTDOORS? — AT NIGHT?

IS YOUR CONDITION WORSE: STANDING? - LAYING DOWN? - DURING OR AFTER EXERCISE? - AFTER A MEAL?

PLEASE LIST ALL CURRENT MEDICATIONS: PRESCRIPTION AND OTC, HERBS, MINERALS, VITAMINS, EYE DROPS, CREAMS, ETC.

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LIST ANY MEDICAL CONDITIONS FOR WHICH YOU ARE BEING TREATED OR WERE TREATED IN THE PAST:

____

____

DO YOU HAVE ANY OF THE FOLLOWING (CIRCLE ALL THAT APPLY): FREQUENT FEVER –SWEATS – CHILLS- WEIGHT LOSS (_____LBS. IN ______MONTHS) WEIGHT GAIN (_____LBS. IN _____MONTHS) - JOINT PAINS – ARTHRITIS – LUPUS – MUSCLE PAINS- IMMUNE PROBLEMS - FREQUENT HEADACHES –NOSEBLEEDS- THYROID DISEASE – DIABETES – OSTEOPENIA OR OSTEOPOROSIS - NASAL POLYPS - SINUS SURGERY – GLAUCOMA - CANCER – PNEUMONIA – TB – HEART CONDITIONS – CHEST PAINS - HIGH BLOOD PRESSURE – HEARTBURN – VOMITING- DIARRHEA – LIVER PROBLEMS – KIDNEY OR URINARY PROBLEMS – ABNORMAL BLEEDING – BRUISING -HIGH CHOLESTEROL – DEPRESSION - ANXIETY

HOSPITALIZATIONS AND SURGERY: PLEASE INCLUDE DATES AND REASONS ____

____

____

FAMILY HISTORY: ALLERGIES – ASTHMA — SINUSITIS — HIVES — ARTHRITIS — DIABETES — HEADACHES — TB – GLAUCOMA – FREQUENT PNEUMONIA — DRUG ALLERGIES — ECZEMA — CYSTIC FIBROSIS (LUNG DISEASE) — EMPHYSEMA – IMMUNE PROBLEMS

HAVE YOU EVER HAD ALLERGY TESTING? Y N WHEN? ____________ WHERE? _______________ RESULTS?___________

HAVE YOU EVER TAKEN ALLERGY INJECTIONS? Y N FOR HOW LONG? _________ REACTIONS? ________ BENEFIT?______

ENVIRONMENT: PLACE OF BIRTH: ____________________ IN OUR AREA FOR _______MO. /YRS. YEAR ROUND? WINTER ONLY?

WHERE DID YOU LIVE BEFORE LIVING HERE? __________________________ ARE YOUR SYMPTOMS WORSE IN FLORIDA?_______

DO YOU FEEL BETTER WHEN YOU LEAVE TOWN? _________ LOCATION: MAINLAND? BEACHSIDE? HOUSE? CONDO?

AGE OF YOUR HOME _____ DO YOU SPRAY FOR INSECTS? _____ WATER INFILTRATION? __________________________

WHAT PETS DO YOU HAVE? ____________________________ IS YOUR HOME ON A CEMENT SLAB? Y N OTHER_____________

TYPE OF FLOORING IN BEDROOM: CARPET — HARD FLOORS (I.E. TILE, WOOD, ETC.) DO YOU USE CEILING FANS? Y N

WHAT IS (OR WAS) YOUR OCCUPATION? ____________________________________ HOBBIES?_____________________

CHEMICAL OR PARTICULATE EXPOSURE? Y N WHAT KIND?____

DO YOU SMOKE? Y N HOW MANY PER DAY _____ (QUIT _____ MONTHS _____ YEARS AGO) SECOND HAND SMOKE? Y N