

PATIENT HISTORY FORM

General Information



Patient's Name _____ Age _____ Sex _____ Date _____
Parent _____ Phone _____
Address _____ Occupation _____
Referred by _____

Medical Information

A. CHIEF COMPLAINTS:

List each complaint and when it started.

- _____
- _____
- _____
- _____
- _____

B. GENERAL SYMPTOMS

1. Pollen Allergy Symptoms

Check line beside symptom

- ___Worse outdoors
- ___Worse on windy days
- ___Worse on clear days
- ___Worse outdoors 7 to 11pm
- ___Worse in change of temperature
- ___Worse in warm or cool air
- ___Better indoors
- ___Better outdoors

2. Dust Allergy Symptoms

Are your symptoms?

- ___Worse indoors
- ___Better outdoors
- ___Worse 30 minutes after retiring
- ___Worse in cold weather
- ___Worse when sweeping
- ___Worse when dusting

3. Mold Allergy Symptoms

Are your symptoms?

- ___Worse outdoors form 4 to 9pm
- ___Worse on cool evenings
- ___Worse in low, damp place
- ___Worse mowing or playing in grass
- ___Worse on windy days

4. Contact Allergy Symptoms

Are your symptoms?

- ___Worse after lights are on 1 hour
- ___Worse in certain rooms
- Which one _____
- ___Worse in basement
- ___Worse near a barn
- ___Worse around animals
- Which ones _____

5. Are your symptoms constant or intermittent? _____

6. During what months do you usually have symptoms:

- ___January ___June ___November
- ___February ___July ___December
- ___March ___August ___All Months
- ___April ___September
- ___May ___October

7. During what months are symptoms most severe?

- ___January ___June ___November
- ___February ___July ___December
- ___March ___August ___All Months
- ___April ___September
- ___May ___October

8. How and when did this condition begin? _____

C. MEDICAL HISTORY

1. What prescription and non-prescription medications do you take?

- ___Aspirin ___Birth Control ___Nose Drops/Sprays
- ___Cortisone ___Antibiotics ___Hormones
- ___Tranquilizers ___Vitamins ___Antihistamines
- ___High Blood Pressure Medication ___Ointments ___Decongestants
- ___Sedatives ___Thyroid Medication ___Anticholesterol Drugs
(Cholestyramine)

List Others

- _____
- _____
- _____
- _____

2. What medications relieve your allergy symptoms? _____

3. Check the following medical conditions you are experiencing or have experienced in the past.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Nasal Surgery | <input type="checkbox"/> Drug Allergy | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Stomach or Intestinal Disease | <input type="checkbox"/> Nasal Polyps | <input type="checkbox"/> Hives |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Milk Allergy | <input type="checkbox"/> Colitis |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> Broken Nose |
| <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Sinus Disease | <input type="checkbox"/> Hay Fever | <input type="checkbox"/> Croup | <input type="checkbox"/> Deviated Septum |

Smoking Habits:

- Cigarettes # _____ / day Years Smoked _____
 Pipe # _____ / day Stopped smoking in _____
 Cigars # _____ / day

Check the following that apply:

- Family Problems Over-anxious
 School Problems Divorced
 Frequently Absent Separated
 School / Work

4. List all surgeries and hospitalizations.

Date	Type Of Surgery	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

5. List physicians you have consulted in the past 5 years for allergy or other medical problems.

Name	Address / Phone	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

D. FAMILY HISTORY

Circle all relatives who have allergic symptoms as described under chief complaint (Page 1). Give cause of allergy when known.

- | | | | | |
|--------|-----------|----------|-------|------------|
| Father | Brother 1 | Sister 1 | Son 1 | Daughter 1 |
| Mother | Brother 2 | Sister 2 | Son 2 | Daughter 2 |

Father's Side of Family

- Grandfather Great Grandfather
 Grandmother Great Grandmother
 Uncle Aunt
 Cousin

Mother's Side of Family

- Grandfather Great Grandfather
 Grandmother Great Grandmother
 Uncle Aunt
 Cousin

Systems Review

A. GENERAL

1. Nose:

- Stuffy
 Runny
 Itching

2. Ears:

- Stopped up feeling
 Itching
 Sore

3. Nasal Blocking:

- Alternating from one side to the other
 Constant
 Night, what time _____
 Day, what time _____
 After meals, how long _____
 Year round
 Seasonal, which _____

4. Mouth:

- Roof itch
 Tongue coated
 Ulcerated
 Lips swell
 Throat itch

5. Eyes:

- Water
 Itch
 Swelling
 Burn

6. Cough:

- Year round
 Seasonal
 Daytime am / pm
 Worse after a cold

7. Itching:

- Eyes
 Ears
 Throat
 Feet
 Hands
 Between shoulders

Worse in:

- Winter
 Spring
 Summer
 Fall

8. Sneezing:

- Year round
 Seasonal
 In early a.m.
 At meal time
 30 minutes after eating
 Smoky places
 Dust

9. General Symptoms:

- Pain, where _____
 Nose Bleed Cannot sleep
 Weight Loss Night sweats
 Tire out easily Temperature
 Colds frequently Sore throats often

B. STOMACH AND INTESTINES

1. Appetite ___ Good ___ Picky ___ Poor
2. Bowels: ___ Regular ___ Constipated
3. Stools: ___ Diarrhea ___ Solid or Mucus ___ Normal
4. Mouth

___ Offensive breath
___ Swallowing difficulties
___ Sores

Stomach

___ Choking feeling
___ Nausea
___ Vomiting
___ Bloating
___ Retasting
___ Gas
___ Indigestion

Rectum

___ Irritated
___ Raw
___ Pain

C. HEART AND ARTERY

1. Labored Breathing

___ Day
___ Night
___ Use pillows
___ How many

2. Weight Loss

___ How much
___ Dieting
___ Diet pills
___ Do diuretics help Y / N

3. Pain in Chest

___ From exercise
___ Difficult breathing
___ Stationary
___ Radiates

4. Swelling

___ Legs
___ Feet
___ Hands
___ Eyes
Time of day a.m. ____ p.m. ____

D. NEUROLOGICAL AND SKELETAL

1. Headaches: How long _____ Onset _____ Regular _____ Periodic _____ Irregular _____
2. Where does it hurt? _____
3. Cerebral: Ringing noises _____ Dizzy _____ Psychosomatic _____
4. Joint Pains: Which one _____ How often _____
5. Muscular Pains: Where _____
6. Bursitis: Where _____
7. Arthritis: Where _____

E. SKIN

1. Sores: Kind _____
2. Hives: _____
3. Rash: What type _____ Where _____

F. GENITOURINARY

1. Urination

___ Painful
___ Delayed
___ Frequent
___ Prolonged
___ Normal
___ Bed Wetting
___ Infections Day _____ Night _____

Environmental Exposures

A. HOME

a. Type

___ Single house
___ Duplex
___ Apartment, floor
___ Hotel
___ Trailer

b. Details

___ Slab or piling foundation
___ Age of house
___ Sheet rock or papered walls
___ Occupancy since

c. Region

___ City, industrial
___ City, residential
___ Suburban
___ Small town
___ Rural

d. Garage attached to house?

___ Yes ___ No

e. Heating and Ventilation

___ Central Heat: Gas / Electric
___ Central Air: Gas / Electric

f. Washer and Dryer

___ Location
___ Gas or Electric

g. Hot Water Heater

___ Location
___ Gas or Electric

h. Houseplants

___ Location
___ Type

B. CHEMICALS IN HOME USE (INDICATE BRAND NAME)

Roach chemical Ant chemical Chlorine cleansers Household cleansers Air fresheners Aerosols

C. COSMETICS (INDICATE BRAND NAME)

Bath powder	Bath soap	After shave	Mascara	Toothpaste	Shampoo	Hair conditioner
_____	_____	_____	_____	_____	_____	_____
Hair coloring	Perfume (or cologne)	Shaving cream	Cold cream	Deodorant	Washing detergent	Fabric softener
_____	_____	_____	_____	_____	_____	_____

D. ANIMALS AND BIRDS (INDICATE TYPE)

Dog (inside or outside)	Cat (inside or outside)
_____	_____
Birds (parakeets, finches, etc.)	Gerbils, hamsters, mice, etc.
_____	_____
Feather pillows? <input type="checkbox"/> Yes <input type="checkbox"/> No	Down jackets, comforters, sofas, etc.?
Mattress & Springs: Age and Type	_____
_____	_____
_____	_____

E. CHECK ANY OF THE FOLLOWING THAT AGGRAVATE YOUR SYMPTOMS:

Paint fumes Mowing lawn Smoke Cooking odors Newspapers Road dust Air pollution Wool

Dietary Habits

Please review each food individually for average frequency of ingestion and mark as follows: D - Daily, F - Frequently (at least every 4 days), S - Sometimes (once every 1-2 weeks), R - Rarely, N - Never. Be sure to include ingredients in food mixtures such as : milk and egg in cookies, wheat in bread, soy in hamburger meat, etc.

A. Vegetables

<input type="checkbox"/> asparagus	<input type="checkbox"/> lettuce
<input type="checkbox"/> beans, lima	<input type="checkbox"/> mushroom
<input type="checkbox"/> beans, navy	<input type="checkbox"/> mustard greens
<input type="checkbox"/> beans, string	<input type="checkbox"/> okra
<input type="checkbox"/> beets	<input type="checkbox"/> onion
<input type="checkbox"/> broccoli	<input type="checkbox"/> parsnip
<input type="checkbox"/> burssels sprouts	<input type="checkbox"/> peas, green
<input type="checkbox"/> cabbage	<input type="checkbox"/> peas, blackeye
<input type="checkbox"/> carrots	<input type="checkbox"/> potato, sweet
<input type="checkbox"/> cauliflower	<input type="checkbox"/> potato, white
<input type="checkbox"/> collards	<input type="checkbox"/> potato chips
<input type="checkbox"/> corn	<input type="checkbox"/> radish
<input type="checkbox"/> celery	<input type="checkbox"/> soybean
<input type="checkbox"/> cucumber	<input type="checkbox"/> spinach
<input type="checkbox"/> eggplant	<input type="checkbox"/> squash
<input type="checkbox"/> garlic	<input type="checkbox"/> tomatoes
	<input type="checkbox"/> turnips

B. Fruits

<input type="checkbox"/> apple	<input type="checkbox"/> lemon
<input type="checkbox"/> apricot	<input type="checkbox"/> lime
<input type="checkbox"/> avocado	<input type="checkbox"/> olive
<input type="checkbox"/> banana	<input type="checkbox"/> orange
<input type="checkbox"/> blackberry	<input type="checkbox"/> peach
<input type="checkbox"/> cantaloupe	<input type="checkbox"/> pear
<input type="checkbox"/> cherry	<input type="checkbox"/> pineapple
<input type="checkbox"/> cranberry	<input type="checkbox"/> plum
<input type="checkbox"/> date	<input type="checkbox"/> prune
<input type="checkbox"/> fig	<input type="checkbox"/> raspberry
<input type="checkbox"/> grape	<input type="checkbox"/> rhubarb
<input type="checkbox"/> grapefruit	<input type="checkbox"/> strawberry
	<input type="checkbox"/> watermelon

C. Vitamins

<input type="checkbox"/> Complex
<input type="checkbox"/> B-12
<input type="checkbox"/> Vitamin C

D. Cereals

<input type="checkbox"/> arrowroot
<input type="checkbox"/> barley
<input type="checkbox"/> cornmeal
<input type="checkbox"/> oats
<input type="checkbox"/> rice
<input type="checkbox"/> rye
<input type="checkbox"/> tapioca
<input type="checkbox"/> wheat (bread)

E. Nuts

<input type="checkbox"/> almond
<input type="checkbox"/> Brazil nuts
<input type="checkbox"/> cashews
<input type="checkbox"/> coconut
<input type="checkbox"/> hazelnut
<input type="checkbox"/> peanut
<input type="checkbox"/> pecan
<input type="checkbox"/> pistachio
<input type="checkbox"/> walnut, black
<input type="checkbox"/> walnut, English

F. Condiments

<input type="checkbox"/> black pepper
<input type="checkbox"/> cinnamon
<input type="checkbox"/> cloves
<input type="checkbox"/> ginger
<input type="checkbox"/> nutmeg
<input type="checkbox"/> paprika
<input type="checkbox"/> pimento
<input type="checkbox"/> sage
<input type="checkbox"/> vanilla
<input type="checkbox"/> yeast, Baker's
<input type="checkbox"/> yeast, Brewer's

G. Meats, Fish, Poultry, & Dairy

<input type="checkbox"/> beef	<input type="checkbox"/> milk
<input type="checkbox"/> catfish	<input type="checkbox"/> pork
<input type="checkbox"/> chicken	<input type="checkbox"/> rabbit
<input type="checkbox"/> duck	<input type="checkbox"/> salmon
<input type="checkbox"/> egg	<input type="checkbox"/> tuna
<input type="checkbox"/> gelatin, Knox	<input type="checkbox"/> trout
<input type="checkbox"/> shrimp	<input type="checkbox"/> turkey
<input type="checkbox"/> Jello	<input type="checkbox"/> veal
<input type="checkbox"/> lamb	<input type="checkbox"/> crab
<input type="checkbox"/> liver	

H. Beverages

<input type="checkbox"/> chocolate
<input type="checkbox"/> Coca-Cola
<input type="checkbox"/> coffee
<input type="checkbox"/> Dr. Pepper
<input type="checkbox"/> tea
<input type="checkbox"/> beer
<input type="checkbox"/> whiskey
<input type="checkbox"/> diet colas

I. Miscellaneous

<input type="checkbox"/> cottonseed (Wesson Oil)
<input type="checkbox"/> safflower oil

Any additional relevant information? _____