Name_____ DOB_____Date_____

How would you like to be addressed? Mr./Mrs./Ms./Dr._____
How did you hear about us? _____
Primary Care Physician _____
Please, describe the reason for the visit today._____
_____
Which pharmacy do you use? _____Where is it located?_____
Demographics (government health care requirement), please **circle all that apply**:

African/African American | Caucasian/European | Hispanic/Latino
American Indian/Alaskan Native/Hawaiian Native/Pacific Islander
Far Eastern Asian /Middle Eastern Asian/Subcontinental Asian

I. HISTORY OF PRESENT ILLNESS

Do you have allergies? YES NO If YES, please **circle** your symptoms:

Stuffy Nose	itchy mouth/ears	Loss of Smell	Mouth Breathing
Runny Nose	Frequent Sneezing	Itchy/red/watery eyes	Bad breath
Post nasal-drip	Nose bleeds	Difficulty hearing	Loss of taste
Throat clearing	Snoring	Sore throat	Voice change
Itchy nose	Nasal polyps	Phlegm	

Other symptoms _____
How long have you had allergies? _____ What time of day is worse? _____
Are symptoms year long? YES NO If NO, what months are worse? _____
Do you have allergies when exposed to any of the following triggers? (Please, circle all that apply)

Grasses	Cats	Stress	Strong odors
Trees	Dogs	Smog	Chemicals
Weeds	Exercise	Menstrual Period	Alcoholic Beverages
Molds	Windy	Smoke	Spicy foods
House Dust	Temperature Changes	Fragrances	Cold Days

Have you ever had skin testing? YES NO If yes, when? _____
Have you ever been on allergy injections (desensitization)? YES NO If yes, when and how long?
_____
Have you had sinus infections in the past? YES NO If yes, how often? _____
Have you had an x-ray or CT scan of your sinuses? YES NO If yes, when? _____

ASTHMA

Have you ever been diagnosed with Asthma? YES NO If YES, year diagnosed_____
If NO, have you or are you experiencing any of these symptoms?
Please, **Circle** any applicable symptoms

Shortness of breath at rest	Cough	Night time awakenings
Shortness of breath with exercise	Chest tightness	Difficulty getting air in
Wheezing	Phlegm	Difficulty getting air out

Name_____ DOB_____Date_____

Other symptoms _____
Year of diagnosis _____Is your activity, including exercise, restricted because of asthma? YES or NO
What worsens your breathing symptoms (e.g. cold air, smoke)?_____
What time of the year does your asthma worsen? _____
How frequently do you have asthma exacerbations? _____ How many nights a week/month?_____
How often do you use your rescue inhaler? _____ Have you ever been intubated?____
Number of ER visits _____ Number of Hospitalizations? _____Number of missed work/school days___
How many times have you needed steroids (pills or injections) for asthma exacerbations?_____
Have you had an x-ray or CT scan of your chest? YES NO If yes, when? _____

ECZEMA OR RASHES

Do you have eczema? YES NO Location of rash _____
How long have you had the rash? _____ What makes the rash worse? _____
What medicines have you used for the rash? _____
What soaps/lotions do you use? _____

HIVES OR SWELLING

Do you have hives or swelling? YES NO Location of the symptoms _____
Please, describe your symptoms _____
How long have you had hives or swelling? _____ What worsens your symptoms?_____
_____
What medicines have you used for the symptoms? _____
Do you have an EpiPen YES NO Have you had a biopsy? _____

OTHER ALLERGIES

Do you have a food allergy or suspected food allergy? YES NO
If yes, what foods and what type of symptoms? _____
Have you eaten these foods since then? YES NO If yes, did you have a reaction? _____
Have you ever had a serious or life threatening reaction to an INSECT STING? YES NO
If yes, what was the reaction? _____
Do you have an EpiPen? YES NO
Are you allergic to LATEX? YES NO If yes, what are your symptoms? _____

II. PAST MEDICAL HISTORY

Have you ever been diagnosed with the following conditions? (Please, list **year** of diagnosis)

_____ Emphysema	_____Cataracts	_____ Diabetes
_____ Bronchitis	_____Glaucoma	_____ Thyroid Disease
_____Pneumonia	_____Reflux disease	_____Cancer/Type _____

Name_____ DOB_____Date_____

_____ Heart/vascular disease _____High blood pressure _____ HIV/AIDS
Other medical conditions _____
Have you had any of the following surgeries in the past? (Please, list approximate dates)
_____Sinus surgery _____ Tonsillectomy/Adenoidectomy _____ Ear Tube Placement
Other surgeries _____
IMMUNIZATIONS: Are your immunizations up to date? YES NO Please list dates of vaccines below
_____Tetanus toxoid _____ Influenza("flu")_____ Pneumococcal ("pneumonia")

MEDICATION HISTORY: Please, list the medications you are currently taking including prescription drugs, medications used occasionally, over-the-counter medications, vitamins, and herbal supplements. You may use the back of this paper, if more space is needed.

Medication Name	Dosage	Frequency
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		
11.		

Please, list and MEDICATION ALLERGIES and symptoms you experienced. _____
_____
Does Aspirin or Ibuprofen cause any allergic or breathing symptoms? YES NO If yes, what kind and how often?_____

III SOCIAL HISTORY

Occupation _____ Who lives at home with you? _____
Marital status _____ Do you have children? _____ Their ages _____
Do you exercise? Yes NO If yes, what type and how often? _____
Do you currently smoke YES NO If yes, # of cigarettes per day?_____For how long?_____
Did you smoke in the past? YES NO If yes, # of cigarettes per day?_____For how long?_____
When did you quit smoking?_____
Do you drink alcohol? YES NO If yes, what kind and how often?_____
Do you use illicit drugs? YES NO If yes, what kind and how often? _____

Name_____ DOB_____Date_____

IV. ENVIRONMENTAL HISTORY

Do you live in a home/apt/condo?_____ How old is your home?_____
Do you have any pets? YES NO If yes, what kind and how many? _____
Do the pets live: Indoors Outdoors Do pets sleep in bedroom? YES NO
Is there anyone that smokes in your home? YES NO Where do they smoke? INDOORS OUTDOORS
Types of trees/greenery around your home? _____
What type of pillows do you use(i.e. feather, down, etc.) _____
Do you have carpet in your bedroom? YES NO If no, what type of flooring? _____
Do you have any upholstered furniture in your bedroom? YES NO
What type of window coverings do you have in your bedroom? _____
Describe your work environment _____
How long have you lived in Central Texas? _____
Where did you live prior to moving to Central Texas? _____

V. FAMILY HISTORY

Has anyone in your family ever been diagnosed with any of the following conditions? (**Circle** all that apply)
Hay Fever Food Allergy Asthma Hives Eczema Immune deficiency
Cancer Coronary Artery Disease Diabetes
What is their relationship to you? _____
Other illnesses in the family _____
Father's age _____ If deceased, age of death and cause _____
Mother's age _____If deceased, age of death and cause_____

VI. For Children Under Twelve (12) Years Old

Birth Weight_____#_____oz Hospital/Location_____
Was the baby born: _____On Time **or** _____ week(s) early_____ week(s) late
Was the delivery: _____ Vaginal _____ Caesarean, why? _____
List any problems during pregnancy or after birth:_____
_____
During pregnancy, did mother:
Smoke? YES NO If yes, explain:_____
Drink? YES NO If yes, explain:_____
Use Drugs or Medications? YES NO If yes, explain:_____
Was the initial feeding _____ Bottle _____ Breast; If breast, for how long? _____
If bottle, type of formula used? _____ For how long? _____
When were solid food introduced? _____ Months

Name_____ DOB_____Date_____

VII. Review of Systems

Do you experience any of the following symptoms? (Please, **check all** that apply)

General ____Fever ____Chills ____Fatigue ____Daytime Sleepiness ____Insomnia ____Weakness	**Genitourinary** ____Blood in Urine ____Urgency ____Burning or Pain ____Incontinence ____Enlarged Prostate ____Kidney Stones	**Pulmonary** ____Cough ____Sputum (color and amount)_____ ____Coughing up blood ____Shortness of breath ____Wheezing ____Chest tightness ____Difficulty Getting Air In ____Difficulty Getting Air Out
Eye ____Redness ____Blurry or Double Vision ____Discomfort ____Glaucoma ____Tearing ____Photophobia ____Cataracts	**Musculoskeletal** ____Muscle or Joint Pain ____Stiffness ____Back Pain ____Trauma	**Gastrointestinal** ____Swallowing difficulties ____Heartburn ____Change in Appetite ____Nausea ____Change in Bowel Habits ____Rectal Bleeding ____Constipation ____Diarrhea
Ears ____Decreased hearing ____Ringing in Ears ____Earache ____Drainage, type_____	**Rheumatologic** ____Redness of Joints ____Swelling of Joints ____Hair Loss	**Psychiatric** ____Nervousness ____Depression ____Memory Loss ____Anxiety ____Stress
Nose ____Stuffiness ____Discharge ____Itching ____Nosebleeds ____Sinus Pain ____Post Nasal Drip ____Snoring ____Mouth Breathing	**Dermatologic** ____Rashes ____Lumps ____Blisters ____Boils ____Itchiness ____Dryness ____Color Changes ____Hives	**Neurologic** ____Dizziness ____Stroke ____Fainting ____Seizures ____Weakness ____Numbness ____Tingling ____Tremor ____Headache-Migraine? Yes or No
Throat ____Sore Tongue ____Dry Mouth ____Sore Throat ____Hoarseness ____Thrush ____Throat Tightness ____Sensation of "sticking" in throat ____Excessive drooling	**Hematologic** ____Easy Bruising ____Easy Bleeding ____Swollen Lymph Nodes	**Allergy** ____Drug:_____ ____Food:_____ ____Chemical:_____ ____Latex ____Insect:_____
Cardiovascular ____Chest Pain ____Palpitations ____Shortness of breath with activity ____Difficulty breathing lying down ____Swelling ____Leg cramping	**Endocrine** ____Heat or Cold Intolerance ____Sweating ____Weight Gain ____Weight Loss ____Frequent Urination ____Thirst ____Change in Appetite	**Immunology** ____Immune Deficiency ____Recurrent Pulmonary Infections ____Recurrent Sinus Infections ____Recurrent Skin Infections

Name_____ DOB_____Date_____

Patient (or Guardian) Signature _____ Date_____

Physician Signature_____ Date_____