

Patient History Form

Name: _____ Date of Birth: _____ Date: _____

Briefly describe your symptoms:

How long have you had these symptoms? _____ Occupation: _____

Time missed from work/school in the last year? _____

Does your job cause /worsen your condition? Yes No

For the following questions-where applicable-place in the corresponding boxes: Y=yes N=no ?-not sure O-not applicable

Do you have any known allergies or have you had an allergic reaction?

To what? _____

Have you been tested for allergies? When? _____ By whom? _____

How? Blood Skin Test

Have you taken allergy shots? For what? _____ How long? _____

Have you had pulmonary (breathing) function tests? When and where? _____

Do you have a history of:

Asthma Hives Emphysema Pneumonia Eczema

Migraine Hay fever Bronchitis Other _____

Do any of your relatives have a history of any of the above conditions?

Who and which ones? _____

Smoking History: Year started: _____ # of cigarettes: _____ Quit? Year: _____

Do any other members of your household smoke?

For the following questions-where applicable-place the corresponding boxes Y=yes N=no ?-not sure O-not applicable

Medications: Note dosage and how many times a day taken
(include those you buy without a prescription)

Drug Allergies:

<i>Drug Name</i>	<i>Type of Reaction</i>

Environmental History:

Numbers of years in: Home Apt Manufactured Farm

Pets Which type and how many? _____ Inside Outside In bed

If on a farm what type of animals are you exposed to? _____

Pillows: Synthetic Feather Floor: Carpet Where? _____

Home Heating: Gas Electric Space heater None

Air Conditioning: Central Window Units None Humidifier Air Filters

What type of air filter? _____

Foods:

Are your symptoms worsened or caused by foods? Which? _____

For the following questions-where applicable-place in the corresponding boxes: Y=yes N=no ?-not sure O-not applicable

Eyes Redness Itching

Ears Popping Fluid Pain/Infection

Throat Frequent infections Hoarseness Postnasal Drip

Nose Stuffy Runny Sneezing Itchy nose

Sinus Infections

Cough In AM During daytime Awakened at night

Dry Productive Color

Frequency: Every day/night 3X/week Once/week Once/month

Shortness of Breath Age of onset _____ Awakened at night Occurs with exercise

Wheezing Awakened at night _____ /week _____ /month

Daytime frequency: daily >2 times/week _____ Times a month

Which of the following cause or worsen your:

Please write in box: **C** (cough) **S** (Shortness of Breath) **W** (Wheeze)

Exercise Smoke Cold Air Alcohol Foods Dust Irritants

Dampness Stress Animals Weather change Colds/Flu Drugs

What are your hobbies? _____

Do you check your peak flows at home? How often? _____ Asthma diary

Additional Comments:
