

PATIENT HISTORY FORM

GENERAL INFORMATION

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

MEDICAL INFORMATION

A. CHIEF COMPLAINTS:

List each complaint and when it started.

1. _____
2. _____
3. _____
4. _____
5. _____

B. GENERAL SYMPTOMS:

- | | | | |
|---|--|---|---|
| 1. POLLEN ALLERGY SYMPTOMS:
Check line beside symptom | 2. DUST ALLERGY SYMPTOMS:
Are your symptoms? | 3. MOLD ALLERGY SYMPTOMS:
Are your symptoms? | 4. CONTACT ALLERGY SYMPTOMS:
Are your symptoms? |
| <input type="checkbox"/> Worse outdoors | <input type="checkbox"/> Worse indoors | <input type="checkbox"/> Worse outdoors from 4 to 9 p.m. | <input type="checkbox"/> Worse after lights are on 1 hour |
| <input type="checkbox"/> Worse on windy days | <input type="checkbox"/> Better outdoors | <input type="checkbox"/> Worse on cool evenings | <input type="checkbox"/> Worse in certain rooms |
| <input type="checkbox"/> Worse on clear days | <input type="checkbox"/> Worse 30 minutes after retiring | <input type="checkbox"/> Worse in low, damp place | Which one _____ |
| <input type="checkbox"/> Worse outdoors 7 to 11 a.m. | <input type="checkbox"/> Worse in cold weather | <input type="checkbox"/> Worse mowing or playing in grass | <input type="checkbox"/> Worse in basement |
| <input type="checkbox"/> Worse in change of temperature | <input type="checkbox"/> Worse when sweeping | <input type="checkbox"/> Worse on windy days | <input type="checkbox"/> Worse near a barn |
| <input type="checkbox"/> Worse in warm or cool air | <input type="checkbox"/> Worse when dusting | | <input type="checkbox"/> Worse around animals |
| <input type="checkbox"/> Better indoors | | | Which ones _____ |
| <input type="checkbox"/> Better outdoors | | | |

5. Are your symptoms constant or intermittent? _____

6. During what months do you usually have symptoms?

- | | | |
|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> June | <input type="checkbox"/> November |
| <input type="checkbox"/> February | <input type="checkbox"/> July | <input type="checkbox"/> December |
| <input type="checkbox"/> March | <input type="checkbox"/> August | <input type="checkbox"/> All Months |
| <input type="checkbox"/> April | <input type="checkbox"/> September | |
| <input type="checkbox"/> May | <input type="checkbox"/> October | |

7. During what months are symptoms most severe?

- | | | |
|-----------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> June | <input type="checkbox"/> November |
| <input type="checkbox"/> February | <input type="checkbox"/> July | <input type="checkbox"/> December |
| <input type="checkbox"/> March | <input type="checkbox"/> August | <input type="checkbox"/> All Months |
| <input type="checkbox"/> April | <input type="checkbox"/> September | |
| <input type="checkbox"/> May | <input type="checkbox"/> October | |

8. How and when did this condition begin? _____

C. MEDICAL HISTORY

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

- | | | | |
|---|---|---|---|
| <input type="checkbox"/> Aspirin | <input type="checkbox"/> Birth Control | <input type="checkbox"/> Nose Drops / Sprays | List Others: _____

_____ |
| <input type="checkbox"/> Cortisone | <input type="checkbox"/> Antibiotics | <input type="checkbox"/> Hormones | |
| <input type="checkbox"/> Tranquilizers | <input type="checkbox"/> Vitamins | <input type="checkbox"/> Antihistamines | |
| <input type="checkbox"/> High Blood Pressure Medication | <input type="checkbox"/> Ointments | <input type="checkbox"/> Decongestants | |
| <input type="checkbox"/> Sedatives | <input type="checkbox"/> Thyroid Medication | <input type="checkbox"/> Anticholesterol Drugs (Cholestyramine) | |

2. What medications relieve your allergy symptoms? _____

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 BIRD (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:

1. Paint fumes 2. Mowing lawn 3. Smoke 4. Cooking odors 5. Newspapers 6. Road dust 7. Air pollution 8. 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

Asparagus	_____	Lettuce	_____
Beans, lima	_____	Mushroom	_____
Beans, navy	_____	Mustard Greens	_____
Beans, string	_____	Okra	_____
Beets	_____	Onion	_____
Broccoli	_____	Parsnip	_____
Brussel Sprouts	_____	Peas, green	_____
Cabbage	_____	Peas, blackeye	_____
Carrots	_____	Potato, sweet	_____
Cauliflower	_____	Potato, white	_____
Collards	_____	Potato chips	_____
Corn	_____	Radish	_____
Celery	_____	Soybean	_____
Cucumber	_____	Spinach	_____
Eggplant	_____	Squash	_____
Garlic	_____	Tomatoes	_____
		Turnips	_____

B. FRUITS

Apple	_____	Lemon	_____
Apricot	_____	Lime	_____
Avocado	_____	Olive	_____
Banana	_____	Orange	_____
Blackberry	_____	Peach	_____
Cantaloupe	_____	Pear	_____
Cherry	_____	Pineapple	_____
Cranberry	_____	Plum	_____
Date	_____	Prune	_____
Fig	_____	Raspberry	_____
Grape	_____	Rhubarb	_____
Grapefruit	_____	Strawberry	_____
		Watermelon	_____

C. VITAMINS

Complex	_____
B-12	_____
Vitamin C	_____

D. CEREALS

Arrowroot	_____
Barley	_____
Commmeal	_____
Oats	_____
Rice	_____
Rye	_____
Tapioca	_____
Wheat (bread)	_____

E. NUTS

Almond	_____	Black Pepper	_____
Brazil Nuts	_____	Cinnamon	_____
Cashews	_____	Cloves	_____
Coconut	_____	Ginger	_____
Hazelnut	_____	Nutmeg	_____
Peanut	_____	Paprika	_____
Pecan	_____	Pimento	_____
Pistachio	_____	Sage	_____
Walnut, black	_____	Vanilla	_____
Walnut, english	_____	Yeast, baker's	_____
		Yeast, brewer's	_____

F. CONDIMENTS

G. MEATS, FISH, POULTRY, & DAIRY

Beef	_____	Milk	_____
Catfish	_____	Pork	_____
Chicken	_____	Rabbit	_____
Duck	_____	Salmon	_____
Egg	_____	Tuna	_____
Gelatin, Knox	_____	Trout	_____
Shrimp	_____	Turkey	_____
Jello	_____	Veal	_____
Lamb	_____	Crab	_____
Liver	_____		

H. BEVERAGES

Chocolate	_____
Coca-Cola	_____
Coffee	_____
Dr. Pepper	_____
Tea	_____
Beer	_____
Whiskey	_____
Diet Colas	_____

I. MISCELLANEOUS

Cottonseed	_____
(Wesson Oil)	_____
Safflower Oil	_____

Any additional relevant information? _____

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:

- | | |
|--|--------------------------------------|
| <input type="checkbox"/> Family Problems | <input type="checkbox"/> Overanxious |
| <input type="checkbox"/> School Problems | <input type="checkbox"/> Divorced |
| <input type="checkbox"/> Frequently Absent From School or Work | <input type="checkbox"/> Separated |

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 (refer to 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

- | | | | | |
|---|---|---|---|---|
| <p>1. Nose:</p> <p><input type="checkbox"/> Stuffy</p> <p><input type="checkbox"/> Runny</p> <p><input type="checkbox"/> Itching</p> | <p>2. Ears:</p> <p><input type="checkbox"/> Stopped up feeling</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Sore</p> | <p>3. Nasal Blocking:</p> <p><input type="checkbox"/> Alternating from one side to the other</p> <p><input type="checkbox"/> Constant</p> <p><input type="checkbox"/> Night, what time _____</p> <p><input type="checkbox"/> Day, what time _____</p> <p><input type="checkbox"/> After meals, how long _____</p> <p><input type="checkbox"/> Year round</p> <p><input type="checkbox"/> Seasonal, which _____</p> | <p>4. Mouth:</p> <p><input type="checkbox"/> Roof itch</p> <p><input type="checkbox"/> Tongue coated</p> <p><input type="checkbox"/> Ulcerated</p> <p><input type="checkbox"/> Lips swell</p> <p><input type="checkbox"/> Throat itch</p> | <p>5. Eyes:</p> <p><input type="checkbox"/> Water</p> <p><input type="checkbox"/> Itch</p> <p><input type="checkbox"/> Swelling</p> <p><input type="checkbox"/> Burn</p> |
| <p>6. Cough:</p> <p><input type="checkbox"/> Year round</p> <p><input type="checkbox"/> Seasonal</p> <p><input type="checkbox"/> Daytime: a.m. _____ p.m. _____</p> <p><input type="checkbox"/> Worse after a cold</p> | <p>7. Itching:</p> <p><input type="checkbox"/> Eyes</p> <p><input type="checkbox"/> Ears</p> <p><input type="checkbox"/> Between shoulders</p> <p><input type="checkbox"/> Throat</p> <p><input type="checkbox"/> Feet</p> <p><input type="checkbox"/> Hands</p> | <p>Worse in:</p> <p><input type="checkbox"/> Winter</p> <p><input type="checkbox"/> Spring</p> <p><input type="checkbox"/> Summer</p> <p><input type="checkbox"/> Fall</p> | <p>8. Sneezing:</p> <p><input type="checkbox"/> Year round</p> <p><input type="checkbox"/> Seasonal</p> <p><input type="checkbox"/> In early a.m.</p> <p><input type="checkbox"/> At meal time</p> <p><input type="checkbox"/> 30 minutes after eating</p> <p><input type="checkbox"/> Smoky places</p> <p><input type="checkbox"/> Dust</p> | <p>9. General Symptoms:</p> <p><input type="checkbox"/> Pain, where _____</p> <p><input type="checkbox"/> Nose bleed</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Tire out easily</p> <p><input type="checkbox"/> Cannot sleep</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Temperature</p> <p><input type="checkbox"/> Sore throats often</p> <p><input type="checkbox"/> Colds frequently</p> |

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
___ Bloating
___ Retasting
___ Gas
___ Indigestion

STOMACH:

- ___ Choking feeling
___ Nausea
___ Vomiting

RECTUM:

- ___ Irritated
___ Flaw
___ Pain

C. HEART AND ARTERY

1. Labored Breathing:

- ___ Day
___ Night
___ Use pillows
___ How many
___ After exercise

2. Weight Loss:

- ___ How much
___ Dieting
___ Diet pills
___ Do diuretics help

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

1. Type:

- Single house _____
Duplex _____
Apartment, floor _____
Hotel _____
Trailer _____

2. Details:

- Slab or Piling foundation _____
Age of house _____
Sheet rock or papered walls _____
Occupancy since _____

3. Region:

- City, industrial _____
City, residential _____
Suburban _____
Small town _____
Rural _____

4. Garage attached to house?

- Yes _____ No _____

5. Heating and Ventilation:

- Central Heat-Gas or Electric _____
Central Air-Gas or Electric _____

6. Washer and Dryer

- Location _____
Gas or Electric _____

7. Hot Water Heater:

- Location _____
Gas or Electric _____

8. Houseplants:

- Location _____
Type _____

B. CHEMICALS IN HOME (Indicate brand name)

- Roach chemical _____ Ant chemical _____ Chlorine cleansers _____ Household cleaners _____ Air fresheners _____ Aerosols _____