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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

- ____ Worse outdoors
- ____ Worse on windy days
- ____ Worse on clear days
- ____ Worse outdoors 7 to 11 a.m.
- ____ 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 from 4 to 9 p.m.
- ____ 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
- ____ February
- ____ March
- ____ April
- ____ May
- ____ June
- ____ July
- ____ August
- ____ September
- ____ October
- ____ November
- ____ December
- ____ All Months

7. During what months are symptoms most severe?

- ____ January
- ____ February
- ____ March
- ____ April
- ____ May
- ____ June
- ____ July
- ____ August
- ____ September
- ____ October
- ____ November
- ____ December
- ____ All Months

8. How and when did this condition begin? _____

_____

_____

C. MEDICAL HISTORY

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

- ____ Aspirin
- ____ Cortisone
- ____ Tranquilizers
- ____ High Blood Pressure Medication
- ____ Sedatives
- ____ Birth Control
- ____ Antibiotics
- ____ Vitamins
- ____ Ointments
- ____ Thyroid Medication
- ____ Nose Drops / Sprays
- ____ Hormones
- ____ Antihistamines
- ____ Decongestants
- ____ Anticholesterol Drugs (Cholestyramine)

List Others: _____

_____

_____

_____

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? _____ Yes _____ 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	___
Cornmeal	___
Oats	___
Rice	___
Rye	___
Tapioca	___
Wheat (bread)	___

E. NUTS

Almond	___
Brazil Nuts	___
Cashews	___
Coconut	___
Hazelnut	___
Peanut	___
Pecan	___
Pistachio	___
Walnut, black	___
Walnut, english	___

F. CONDIMENTS

Black Pepper	___
Cinnamon	___
Cloves	___
Ginger	___
Nutmeg	___
Paprika	___
Pimento	___
Sage	___
Vanilla	___
Yeast, baker's	___
Yeast, brewer's	___

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:

____ High Blood Pressure	_____Nasal Surgery	____ Drug Allergy	____ Emphysema
_____Thyroid Dysfunction	_____Stomach or Intestinal Disease	____ Nasal Polyps	____ Hives
_____Seizures	_____Heart Disease	____ Milk Allergy	____ Colitis
_____Bronchitis	_____Arthritis	____ Frequent Headaches	____ Broken Nose
_____Skin Disease	_____Asthma	____ Migraine Headaches	____ Ulcers
_____Sinus Disease	_____Hay Fever	____ Croup	____ Deviated Septum

Smoking Habits:

Cigarettes # _____ /day
Pipe # _____ /day
Cigars # _____ /day

Years Smoked _____
Stopped Smoking in _____

Check the following that apply:

_____ Family Problems
_____ School Problems
_____ Frequently Absent From School or Work
_____ Overanxious
_____ Divorced
_____ 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
Grandmother
Uncle
Cousin
Great Grandfather
Great Grandmother
Aunt

Mother's Side of Family

Grandfather
Grandmother
Uncle
Cousin
Great Grandfather
Great Grandmother
Aunt

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: a.m. ____ p.m. ___
___ Worse after a cold

7. Itching:
____ Eyes
____ Ears
____ Between shoulders
____ Throat
____ Feet
____ Hands

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
___ Weight loss
___ Tire out easily
____ Cannot sleep
____ Night sweats
____ Temperature
____ Sore throats often
____ Colds frequently

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
___ Raw
___ 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	Clorine cleansers	Household cleaners	Air fresheners	Aerosols
_____	_____	_____	_____	_____	_____