Patient Name _____ **Date of Birth** _____ **Primary Care MD** _____ **Date** _____

WHY YOU ARE HERE TODAY? **BE *VERY SPECIFIC* AND DETAILED**

_____

_____

Any **medication** or **activity** make it **better**?_____

Any **medication** or **activity** make it **worse**?_____

Review Each Item Carefully. Circle ALL SYMPTOMS you may have experienced ANY TIME since BIRTH.

Symptoms are Present:
Spring
Summer
Fall
Winter
All Year

Symptoms are Worse During:
Morning
Afternoon
Evening
Night
No particular time of day

General Problems:
Repeated Infections
Insect Allergy
Food Allergy
Drug Allergy

Eyes:
Frequent Itching
Excessive Tearing
Redness/Irritation
Yellow Mucus or Matting in eyes
Dryness
Blurring of vision
Puffiness of Lids and Under Eyes

Ears:
Popping
Stuffed or "Under Water"
Itchy
Pressure/Fullness
Pain
Hearing Loss
Dizziness

Head:
Headaches
Sinus Pressure:
Forehead
Behind Eyes
Cheeks
Teeth/Jaw

Nose:
Nasal Congestion (Stuffiness)
Mouth Breathing
Frequent Sneezing
Nose Itches
Snoring
Runny / Drippy
Sniffling
Frequent Nose Blowing
Frequent Nose Bleeds
Loss of Ability to Smell
History of Polyps

Lungs:
Chest Symptoms with Exercise
Chest Tightness / Chest Heaviness
Coughing at Night
Coughing during Day
Rattling Wet Productive/Mucousy Cough
Chest Pain Back Pain or "Kink" in the side of your chest
Wheezing (whistling in the chest)
Dry Cough with Tickle in Throat
Difficulty Taking in a Deep Breath
Shortness of Breath / Air Hunger
Coughing Fits
Awakening Short of Breath
Frequent Sighing or Yawning

Throat:
Mucous down back of throat (Post Nasal Drip)
Colored (not clear) Mucous in throat or expectorated
Lump of Mucous in back of Throat upon arising
Sore Throat or Scratchy Throat upon arising
Itchy Throat
Coughing or Clearing to move Mucous out of back of Throat
Hoarseness Voice Loss

Skin:
Very dry, scaly skin (Must use Lotion Daily)
Bumpy Rash (can feel with eyes shut)
Smooth Rash (skin color change only)
Scaly Rash
Hives (or Welts…look like mosquito bites)
Swelling
Itching
Blisters
Color of Rash (if any) _____

Gastrointestinal: (please name food)
History of Food Allergy/Reaction
Nausea after eating a certain Food which? _____
Vomiting after eating a certain Food which? _____
Diarrhea after eating a certain Food which? _____
Abdominal Pain after eating a certain Food? which? _____
Cramps/ Colic/ Gas after eating a certain Food? which _____
Hives after eating a certain Food
Bringing up your Food or frequent Burping
Heartburn / Acid Indigestion / Gastric Reflux
Food gets "stuck" when you swallow it without water

Reviewed with Patient ____

Patient Name _____ **Date of Birth** _____ **PCP** _____ **Date** _____

Medications you use or have used (Name all those you can remember**):**
Antihistamines Fexofenadine Alavert Loratidine Claritin Zyrtec Cetirizine Allegra ChlorTrimeton Clarinex Xyzal Benadryl
Decongestants Mucinex Pseudafed Motrin Sinus Tylenol Sinus Actifed Tavist D
Nasal Sprays Saline Astelin Afrin NeoSynephrine Nasonex Rhinocort Flonase Nasacort Nasalcrom Fluticasone Omnaris Veramyst Astepro Dymista
Inhalers Atrovent Flovent Advair Asmacort Albuterol Proventil Ventolin ProAir Xopenex Spiriva Foradil Ipratropium Combivent Qvar Pulmicort Asmanex MaxAir Symbicort Dulera Serevent Tudorza
Nebulizer Treatments (mist machine) Ipatropium Intal Albuterol Levalbuteral Xopenex Pulmicort Budesonide Foradil Brovana Peroformist **Do You own a Nebulizer Machine?** Yes No
Eye Drops (for itch or tearing) _____Patanol Crolom Livostin Visine Singulair Xolair Injections

Past Medical History (***EVERYTHING SINCE BIRTH***):Eczema Hepatitis Thyroid Disease High Cholesterol Depression Insomnia Asthma COPD Bronchitis Pneumonia Sinusitis Ear Infection Nasal Polyp High B/P Diabetes GI Reflux Sleep Apnea Chickenpox
ALL Other Illnesses you've EVER had_____
ALL Surgeries you've EVER had_____Tonsils Adenoid
ALL Injuries/Fractures you've EVER had_____
Do you Sleep 8 hrs? N Y Dream when Asleep? N Y Every Night? N Y Take Sleep Medication? N Y _____
Are you Nursing? N Y Pregnant? N Y How many weeks? _____ Which one?
Have you EVER had an Anesthesia Reaction? N Y _____ Vaccine Reaction? N Y _____
Do you react to latex? (condoms, diaphragm, gloves, etc.) N Y Describe: _____
Have you EVER been *Skin* Tested for Allergies? N Y Which were Positive?_____
Have you EVER been on Allergy Shots? N Y When?_____ What Allergens were in the shots?_____
What Physicians have you seen for this problem? (Name & Specialty) _____

NAME ALL ANTIBIOTICS you've been on ***EVER*** **(Please Call your pharmacy NOW if you can't recall)**
Amoxil Augmentin Amoxil/Clavulinate Azithromycin Avelox Bactrim Biaxin Ceclor Cefdinir Ceftin Cefzil Cipro Clarithromycin Doxycycline Dicloxacillin Erythromycin Flagyl Floxin Keflex Ketek Levaquin Metronidazole Minocycline Zyvox Omnicef Pediazole Penicillin Rocephin Septra Sulfa Suprax Tequin Tetracycline Vantin Zithromax Zpak

Birth History Birth Wt _____ Vaginal or C-Section Term Baby or Preemie How Many Weeks ____?
Problems at Birth or 1st Month?_____ *Cradle Cap* (dry crusty scalp) at 1 mos old? Y N Don't Know

*Do any of your **blood relatives** have any of the following illnesses?*	**PLEASE CHECK UNDER PROPER COLUMN** *Father's (Aunts, Uncles) Family (Grandparents)*	*Mother's (Aunts, Uncles) Family (Grandparents)*	*Your Children*	*Your Brothers / Sisters*
Nasal or Sinus Illness				
Ear Infections				
Asthma or Bronchitis				
Emphysema or COPD				
Skin Allergic Problems				
Dermatomyositis				
Lupus				
Diabetes				
Arthritis				
Cystic Fibrosis				
Inflammatory Bowel Dz				
Thyroid Dz				
Psoriasis				

REVIEW OF SYSTEMS (circle those which you may have**):** **NONE OF THESE APPLY TO ME (if so Please Circle)**
GENERAL: Fatigue Fevers Vertigo Recent weight loss Recent weight gain
HEENT: Bloody nose Blurred vision Wear glasses Ears ringing
CARDIOVASCULAR: Chest pains Palpitations/skipped beats Swollen ankles
PULMONARY: Difficulty breathing laying down (use more than 1 pillow) Stop breathing while asleep Wake up Gasping
GENITOURINARY: Up at night to urinate Frequent urination Difficulty starting a stream
GASTROINTESTINAL: Blood in stool Constipation Burping (without drinking soda)
MUSCULOSKELETAL: Joint pain Back pain Limited joint motion Joint swelling
IMMUNE: Lymph Nodes you can feel
HORMONES: Frequent Thirst Heat Intolerance Cold Intolerance Hair loss
SKIN: Dry scalp Itchy scalp Dry skin only in Winter
NEUROLOGICAL: Insomnia Early Morning Awakening Running Lists in Mind at Bedtime Not Dreaming Nightly

Reviewed with Patient ____

Patient Name _____ **Date of Birth** _____ **PCP** _____ **Date** _____

Your Environment *PLEASE CIRCLE ALL THOSE THAT APPLY TO YOU*

Where do you live? (What area of Florida…City?)_____

Older House/Apartment (***more than one year old***?)
Garage
Attic
Basement
Fireplace
Central Electric Heat in Baseboard
Central Electric Heating in Air Conditioning
Gas Heat
Central Air Conditioning without Heating
Window Unit A/C

New Home/Apartment (***less than one year old***)
Near Factories
Near Wooded Areas
Near Highways
Construction In or Near Your House
Near Body of Water
Evaporative Cooler (Swamp Fan)
Ceiling Fan or Floor Fan
Attic Fan or Window Fan
Electrostatic or HEPA Filters in A/C

In Your Bedroom Do You Have?
Feather/Down Pillow
Regular Foam Pillow
Plastic/Allergy Pillow or Mattress Covers
Wool Blankets
Down or Feather Comforter
Many Books
Antique Furniture or Cushions
Wallpaper
Dusty Closets
Stuffed Animals
Venetian Blinds
Vertical Blinds
Carpeting (wall to wall)
Rugs (area)
Tile Laminate
Sleep with Animals in Room N Y

In Your Home Do You Have?
Opens Vents to Outside
Indoor Water Leaks or Mildew
Many Plants Indoor
Pets (type?)_____ Indoor? Outdoor?
Carpeting (wall to wall)
Rugs (area)
Tile Laminate
Venetian Blinds
Vertical Blinds
Many Books
Antique Furniture or Cushions
Many Dust Collectors (Bric-a-Brac aka "Chachcas")
Wallpaper
Cigarette Smokers (in or outside) or Smoke Exposure
Any Moldy or Humid Areas in House? N Y _____
Pool

At Work or School

What is your Occupation? _____
Windows Sealed or None Existent
Near Gases or Irritant Chemicals
Near or Under Construction
Mildew or Damp Areas
Near or Directly Under Fans or Air Vents
Portable or Temporary Bldg
Cigarette Smoke Exposure
Very Cold or Very Warm Temp

List any of the features or characteristics you believe may be triggering your problem which may apply to Work or School:

Second Hand Smoke Exposure? No Yes At Home At Friends At Family's In Auto At Work "Outside" Smokers
Do you Smoke? Y N **Did you ever smoke in the past?** Y N **If Yes, how long did you Smoke?** ___ yrs
How much did/do you smoked per day? _____ **Have you Quit?** Y N If so , **When**? ___ yrs ago
What did you smoke ? Cigars Cigarettes Pipe Marijuana Inside Home Outside Home In Auto
Since birth have you lived with Smokers (inside or outside smokers)? N Y How long did you live with them? _____

Do you consume alcohol? N Y Beer Wine Hard Liquor **Do you partake of Recreational Drugs?** Y N
Have you traveled outside of the United States in the last 6 months? N Y Explain: _____

HOBBIES

Did you sing often at *any time* in your life (shower or car)? Y N
Did you play a wind instrument at *any time* in your life? Y N Did you swim often at *any time* in your life? Y N
Did you run often at *any time* in your life? Y N Do you breath-hold while running or exercising or weight lifting? Y N
Did you do Yoga / Breathing Exercises at *any time* in your life? Y N

WHEN EATING THESE FOODS ***rash***, ***runny nose, headache, cough, chest tightness, wheezing, sudden diarrhea, stomach-ache, itchy mouth or throat ?*** N Y **(please circle foods and symptoms)**

Milk	Fish	Corn	Bananas	Others _____
Eggs	Shell Fish	Watermelon	Citrus Fruits	Food Additives
Wheat	Peanut	Celery	Alcoholic Drinks	Food Coloring
Cheese	Soy	Tomatoes	Wine	Chinese Food
Butter / Yogurt	Other Nuts _____	Apples	Beer	MSG

Reviewed with Patient _____

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Insect Bit Reactions? N Y ***What symptoms were <u>associated with the BITE</u>:*** Hives Dizziness Swelling Diarrhea Airway (Throat)Swelling Wheezing Chest Tightness Shortness of Breath Large Red Area Around Bite

Please name or describe the Insect or the Hive _____ When were you last bitten? _____

Do the following make you *Worse*, *Improve* the present condition or *Change Nothing*?

write next to each item W for worse B for better N/C for no change

Antihistamines	Paints, Varnishes	Dusting, Vacuuming	Humid Weather Rainfall
Nasal Sprays or drops	Perfumes, Scents	Chalk Dust	Raking Wet Leaves
Asthma Inhalers	Hair Sprays	Construction	Mold or Mildewy Areas
Aspirin or Ibuprofen	Cosmetics	Windy Weather, Breeze	Barn Dust or Hay
Cold Preparations	Strong Odors	Direct Fan Air	Changes in Altitude
Cigarette Smoke	Cooking Odors	Direct A/C Vent Air	Contact with Grass
Cleaning Agents	Eating Spicy Foods	Cold Drafts	Heavy Exercise, Sports
Laundry Soaps	Contact with Animals	Weather Change	Emotional Stress
Car w/ Open Roof	Riding Motorcycle	Temperature Change	Talking or Singing

What Medications are you on TODAY? List ALL with doses….(<u>include vitamins and natural medicines</u>).
It is very important <u>*ALL*</u> be listed so we do not prescribe medications which may interact with them.

_____
_____
_____
_____
_____
_____

REACTIONS TO <u>ANY</u> MEDICATIONS *<u>EVER</u>*? N Y PLEASE DESCRIBE (where, when, appearance, symptoms etc.)

MEDICATION	**REACTION**

ONLY for Patients Coming in for SKIN PROBLEMS

When did you present skin problems begin? _____
Have you ever had this rash before? N Y _____
How often does it present? 1-2 Days/Wk 4–6 Days/Wk Everyday Every ___Mins Every ___ Hours
How long does the skin problem persist? ___Mins ____Hrs ___Days ___Weeks ___Months
When is the worst time of day? Morning Afternoon Evening Night Anytime
Have you had any significant swelling? N Y Where? _____
When you close your eyes, can you feel the rash? Y N Does the rash have a color? N Y _____
Is the affected skin: Scaly Itchy Warm to Touch Tender to Touch Under Clothing Exposed Skin Blister
Illness or event associated to the presentation of this problem? (fever, cold, new med, vaccine, etc.) N Y
Explain:_____
Have you had fever with the skin disorder? N Y Explain:_____
Were you treated at the ER by a physician for the skin condition? N Y What was prescribed or done?
_____
Have you had any blood work done for this condition? N Y Explain: _____
Is there a food, herb, spice, additive, candy which triggers your reaction ***<u>EVERY TIME YOU EAT IT</u>***? N Y
Explain:_____
What medications do you use for pain? _____
Do you contact with animals, insects, plants, chemicals? No Yes Explain: _____
What is your water source? **HOME:** City Well Bottle Filtered **WORK:** City Well Bottle Filtered
Do you handle chemicals at Work? Home? Hobby? N Y Explain:_____

Revised 1.5.2015

Reviewed with Patient ____