ALLERGY AND ASTHMA ASSOCIATES OF PITTSBURGH

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Please complete as carefully as possible. All information is confidential.

Date: _____

Patient Name: _____DOB: _____ Age: _____

Street Address: _____ Primary Care Physician: _____

City: _____State: _____ Zip Code:_____ Referred By: _____

Home Phone: _____ Cell Phone: _____

Place of Employment: _____ Work Phone: _____

Marital Status: (please circle one) Single Married Divorced Widow/Widower

Please briefly state the reason for today's visit: _____

_____

Symptoms: (check all that apply)

	Yes	No		Yes	No
Runny nose	( )	( )	Wheezing	( )	( )
Itchy or watery eyes	( )	( )	Chest tightness / Pressure	( )	( )
Sneezing	( )	( )	Shortness of breath	( )	( )
Nasal congestion	( )	( )	Headaches	( )	( )
Drainage down the throat	( )	( )	Vomiting	( )	( )
Frequent yellow or green nasal drainage	( )	( )	Diarrhea	( )	( )
Snoring	( )	( )	Abdominal pain	( )	( )
Breathing through the mouth	( )	( )	Hives	( )	( )
Coughing	( )	( )	Swelling	( )	( )
			Eczema	( )	( )

Frequent infections: (types and Frequency)

_____

_____

Other symptoms: (please list) _____

_____

How long have you suffered with these symptoms? _____

My allergy symptoms occur: (check all that apply)

( ) Spring ( ) Summer ( ) Fall ( ) Winter ( ) Year round ( ) At home: (which rooms?) _____
( ) At work ( ) At school ( ) Outdoors ( ) Indoors ( ) Morning ( ) Night ( ) All day

My Allergy symptoms are made worse by: (check all that apply)

( ) Colds
( ) Cigarette smoke
( ) Mowing grass
( ) Raking leaves
( ) Perfumes, colognes, scents and odors
( ) Dusting / Cleaning
( ) Feathers
( ) Changes to the temperature and / or relative humidity
( ) Foods
( ) Milk and dairy
( ) Dogs
( ) Cats
( ) Hot Weather
( ) Cold weather
( ) Exercise
( ) Other_____

Please answer the following questions if you have asthma:

When was the diagnosis made? _____

How often do you experience asthma symptoms? _____

Do you have nighttime symptoms? Yes _____ No _____

How often do you use your rescue inhaler? (ie: Albuterol) _____

Do you experience GERD symptoms (heartburn)? Yes _____ No _____

Number of missed work/school days in the past year: _____

Number of courses of systemic steroids: (ie: Prednisone, Medrol) _____
When was the last course? _____

Number of emergency room visits: _____ Date of last emergency room visit: _____

Number of hospital admissions: _____ Date of last admission: _____

Number of ICU admissions: _____ Date of last ICU admission: _____

Have you ever had a breathing test (PFT)? Yes _____ No _____

When was your last PFT performed? _____

Do you have a peak flow meter? Yes _____ No _____

What is your personal best? _____

Environmental Exposures:

	Yes	No		Yes	No
Dogs: (Number _____)	( )	( )	Carpets / Rugs	( )	( )
Cats: (Number _____)	( )	( )	Air cleaners	( )	( )
Birds: (Number _____)	( )	( )	House Plants	( )	( )
Other pets: (Number _____)	( )	( )	Damp basement	( )	( )
Type _____	( )	( )	Stuffed toys	( )	( )
Feather pillow (s)	( )	( )	Water bed	( )	( )
Down comforter	( )	( )	Improved away from home	( )	( )

Drug Allergies: Please list medication names and describe reactions:

Drug Name:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Food Allergies: Please list foods and describe reactions:

Food:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Insect Sting Allergy: Please list insect and describe reaction:

Insect**:**	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Latex Allergy: Please describe reaction if sensitive to latex:

_____
_____
_____
_____

Medical History: Please list all current and past medical problems, hospitalizations and surgeries:

Medications: Please list all current medications including over the counter medications and herbal supplements:

Medication:	Dose:	Time taken:

Laboratory Test and Studies: Please list all relevant tests and studies performed with dates and locations:
(ie: bloodwork, allergy testing, x-rays, CT scans, MRI's etc…)

Test:	**Date**:	**Location**:

Immunization History:

	Yes	No	Dates:
Diphtheria, Pertussis, Tetanus	( )	( )	_____
Polio	( )	( )	_____
Measles, Mumps, Rubella	( )	( )	_____
Haemophilus Influenza	( )	( )	_____
Influenza (flu vaccine)	( )	( )	_____
Pneumococcal	( )	( )	_____
Varicella (chicken pox)	( )	( )	_____
Hepatitis A	( )	( )	_____
Hepatitis B	( )	( )	_____
Zostavax (shingles)	( )	( )	_____
Tetanus booster	( )	( )	_____
Human Papillomavirus (HPV)	( )	( )	_____
Meningococcal (meningitis)	( )	( )	_____
Rotavirus	( )	( )	_____
Other (Names)	( )	( )	_____

_____

Family History: Please list medical conditions including allergies:

Father: _____
Mother: _____
Brothers: _____
Sisters: _____
Sons: _____
Daughters: _____
Other Relatives: _____

Social History: Circle one

Do you currently smoke? (Yes) (No) How many per day? _____ How long have you smoked? _____

Have you ever smoked? (Yes) (No) How many per day? _____ How long did you smoke? _____

When did you stop smoking?_____

Do you drink alcohol? (Yes) (No) How much? _____ How often? _____

Do you use any other recreational drugs? (Yes) (No) If yes please list: _____

Current occupation:

_____

Hobbies:

_____

Review of Systems: Please circle the symptoms that trouble you. If needed, provide additional information in the spaces provided. Systems left unmarked will be considered negative.

CONSTITUTIONAL: Fatigue Malaise Fever Sweats Chills Unexplained weight loss

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EYES: Red eyes Watery eyes Itchy eyes Puffy eyes Problem with vision Eye pain

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EARS / NOSE / MOUTH / THROAT: Earache Itchy ears Decreased hearing Ear plugging Ringing in the ears Ear drainage Nasal congestion Runny nose Itchy nose Excessive sneezing Frequent nasal bleeding Sinus pain Mouth breathing Snoring Sore Throat Itchy throat Tooth or gum pain Post nasal drip

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CARDIOVASCULAR: Chest pain Rapid heart rate Irregular heart beat Shortness of breath Problems lying flat Calf pain with walking

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RESPIRATORY: Shortness of breath Cough Wheezing Chest tightness Night time chest symptoms Shortness of breath with exertion

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GASTROINTESTINAL: Heartburn Difficulty swallowing Painful swallowing Nausea Vomiting Diarrhea Constipation Abdominal pain

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Genitourinary: Frequent urination Painful urination Blood or pus in urine Frequent night time urination Urgency

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MUSCULOSKELETAL: Joint pain Joint swelling Muscle pain Muscle weakness

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INTEGUMENT: Itching Eczema Hives Swelling Easy bruising

NEUROLOGIC: Headaches Altered vision Seizures Muscle weakness Dizziness Vertigo Difficulty walking

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PHYCHIATRIC: Depressed Anxious Stressed Sad Difficulty getting to sleep or staying asleep Poor appetite

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ENDOCRINE: Goiter Bulging eyes Intolerance of heat or cold Hand tremor Excessive appetite Weight gain Weight gain Weight loss Frequent urination Problems with vision

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HEMATOLOGY / LYMPHATIC: Easy bruising Frequent bleeding of the nose or gums Excessive menstrual bleeding, Anemia Enlarged or painful lymph nodes weight loss

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