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)

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____

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 pm trips (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:

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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

___

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

___

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

___

MUSCULOSKELETAL: Joint pain Joint swelling Muscle pain Muscle weakness

___

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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