# NORTHERN ARIZONA ALLERGY, ASTHMA, & IMMUNOLOGY

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PATIENT HISTORY FORM

PATIENT NAME: _____ GENDER: FEMALE / MALE PATIENT DOB: _____/_____/_____

DOES PATIENT GO BY ANOTHER NAME? _____ PRIMARY CARE PHYSICIAN: _____

**Attention!**

**All questions that are being asked are very important.**

We ask that you:

Fill out **EVERY** section and answer all questions with either

**YES/ NO**

**&**

**CIRCLE**

your answers when necessary.

Please provide as much information as possible, as this information is used to understand the reason for your visit today.

***WHAT PROBLEMS DO YOU NEED EVALUATED TODAY?***

**Please (circle) ALL symptoms**

1. **HAY FEVER**
2. **NASAL PROBLEMS**
3. **SINUS PROBLEMS**
4. **BREATHING DIFFICULTIES (ASTHMA/ BRONCHITIS/ COUGHING)**
5. **FOOD REACTION (EOSINOPHILIC ESOPHAGITIS (E.E)/ ANAPHYLAXIS/ CELIAC SENSITIVITY)**
6. **ESTABLISH LOCAL CARE (NEW PATIENT EVALUATION)**
7. **SKIN PROBLEMS (HIVES / ECZEMA/ RASH)**
8. **EAR PROBLEMS**
9. **INSECT REACTION (LOCAL REACTION)**
10. **HEADACHES**
11. **FOLLOW- UP/ ESTABLISHED**
12. **IMMUNOLOGY CONSULT**
13. **OTHER:_____**

_____

***WHAT ARE YOUR SYMPTOMS? (PLEASE REPLY TO ALL QUESTIONS.) If none of these symptoms apply to you/ the patient, please mark the boxes below each section.***

NASAL SYMPTOMS: **Please (circle) symptoms if they apply.**

HOW FREQUENT ARE THEY? DAILY WEEKLY MONTHLY SEASONALLY

1. **Nasal discharge** YES/ NO
2. **Post nasal drip** YES/ NO
3. **Sneezing** YES/ NO
4. **Nasal itchiness** YES/ NO
5. **Nasal congestion** YES/ NO
6. **Frequent nose blowing** YES/ NO
7. **Loss of smell/ taste** YES/ NO
8. **Throat itchiness** YES/ NO

☐ **I/ the patient DO NOT have any nasal symptoms.**

SKIN SYMPTOMS: **Please (circle) symptoms if they apply.**

1. **Hives/ Welts/ Red patches/ Itchiness** YES/ NO
2. **Eczema** YES/ NO
3. **Swelling** YES/ NO
4. **Recent skin infection** YES/ NO
5. **Recent antibiotic use for skin only** YES/ NO
6. **Do you have a family history of swelling or eczema?** YES/ NO

☐ **I/ the patient DO NOT have any skin symptoms.**

EYE SYMPTOMS: **Please (circle) symptoms if they apply.**

1. **Itchiness, redness, puffiness** YES/ NO
2. **Watery discharge** YES/ NO
3. **Eyelid irritation** YES/ NO
4. **Dark circles under eyes** YES/ NO
5. **Do you use eye drops?** YES/ NO

**HOW OFTEN? _____**

☐ **I/ the patient DO NOT have any eye symptoms.**

CHEST SYMPTOMS: **Please (circle) symptoms if they apply.**

HOW FREQUENT ARE THEY? DAILY WEEKLY MONTHLY SEASONALLY

1. **Chest tightness** YES/ NO
2. **Coughing up mucus or blood** YES/ NO
3. **Acid reflux/ GERD** YES/ NO
4. **Cough/ chest tightness w/ excercize** YES/ NO
5. **Interupted sleep from cough** YES/ NO
   **How many nights per week? _____**
6. **Do you use inhalers/ Albuterol?** YES/ NO
7. **Do you use a nebulizer?** YES/ NO
8. **Do you have a peak flow meter?** YES/ NO
9. **How many severe episodes have you had in the last year? _____**
10. **Have you used oral steroids for asthma (Prednisone) lately?** YES/ NO
11. **Have you been hospitalized/ ER visit for chest problems/ asthma, pneumonia?** YES/ NO

*** WHEN DID THIS OCCUR? _____**

☐ **I/ the patient DO NOT have any chest symptoms.**

SINUS SYMPTOMS: **Please (circle) symptoms if they apply.**

1. **Frequent sinus infections** YES/ NO
2. **Facial pain/ tenderness** YES/ NO
3. **Tooth pain** *(ONLY ASSOCIATED WITH SINUS ISSUES)* YES/ NO
4. **Pressure or congestion** YES/ NO
5. **Colored nasal discharge** YES/ NO
6. **Headaches** YES/ NO
7. **Prednisone for sinusitis** YES/ NO

☐ **I/ the patient DO NOT have any sinus symptoms.**

PATIENT NAME: _____ D. O. B. _____

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## *WHAT TRIGGERS YOUR SYMPTOMS?* (CIRCLE) ALL THAT APPLY

**ALLERGIES:**

1. POLLENS
   GRASS WEEDS TREES
2. ANIMALS
   CAT DOG BIRD GERBIL OTHER: _____
3. MOLD/ MILDEW
4. DUST

☐ **NONE OF THESE TRIGGER MY SYMPTOMS**

**IRRITANTS:**

1. WEATHER CHANGES
2. WIND
3. COLD AIR / HUMIDITY
4. EXERCISE
5. STRONG ODORS
6. FIREPLACE/ SMOKE
7. PERFUMES
8. CHEMICALS
9. TOBACCO SMOKE

☐ **NONE OF THESE TRIGGER MY SYMPTOMS**

**OTHER: (DO THESE OPTIONS TRIGGER YOUR SYMPTOMS?)**

1. ANTIBIOTICS
2. ASPIRIN
3. EMOTIONS
4. STRESS
5. CRYING
6. VIRAL COLDS
7. SINUS INFECTIONS
8. LATEX

☐ **NONE OF THESE TRIGGER MY SYMPTOMS**

**WHAT MONTHS DO YOU HAVE PROBLEMS? (CIRCLE) ALL THAT APPLY**

**NOSE/EARS:** JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

**SINUS:** JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

**CHEST:** JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

**EYES:** JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

**SKIN:** JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

***PREVIOUS ALLERGY CARE*** (CIRCLE) **ALL THAT APPLY**

1. HAVE YOU EVER BEEN TESTED FOR ALLERGIES BEFORE? **YES** **NO**
   IF YES, PROVIDE THE DATE AND WHERE THE OFFICE WAS LOCATED: _____
2. TESTED BEFORE: SKIN TESTING BLOOD TESTING
   WERE YOU POSITIVE TO: GRASS WEEDS TREES DUST MITE ANIMALS MOLDS FOOD OTHER: _____
3. HAVE YOU EVER HAD ALLERGY TREATMENT SHOTS? **YES** **NO**
   WHO WAS THE DOCTOR AND LOCATION? _____
   STARTING DATE TO ENDED DATE: _____ DID THEY HELP? NONE SLIGHT MODERATE GREAT
4. PREVIOUS SINUS X-RAY OR CT SCAN? **YES** **NO**
5. PREVIOUS EAR/NOSE/THROAT OR PULMONARY EVALUATION? **YES** **NO**

## REVIEW OF SYSTEMS:

INDICATE WHETHER OR NOT YOU/ THE PATIENT HAVE EXPERIENCED THE FOLLOWING SYMPTOMS DURING RECENT MONTHS, UNLESS OTHERWISE SPECIFIED, BY CHECKING **YES** OR **NO** FOR EACH QUESTION. **PLEASE (CIRCLE) THE SYMPTOMS YOU HAVE EXPERIENCED WHEN MULTIPLE ARE LISTED.** PLEASE PROVIDE AN EXPLANATION IF NEEDED.

| SYMPTOMS | YES | NO | EXPLAIN |
|---|---|---|---|
| 1. SKIN RASH, HIVES ITCHINESS, DRY SKIN | | | |
| 2. ANGIOEDEMA (SWELLING) OF LIPS OR FACE | | | |
| 3. COLD INTOLERANCE | | | |
| 4. DIFFICULTY MOVING LEGS OR ARMS, TREMOR | | | **(L)** LEG / **(R)** LEG / BOTH -- **(L)** ARM / **(R)** ARM / BOTH |
| 5. NUMBNESS OR TINGLING IN HANDS OR FEET | | | **(L)** FOOT / **(R)** FOOT/ BOTH -- **(L)** HAND / **(R)** HAND / BOTH |
| 6. CATARACTS | | | **(L)** EYE / **(R)** EYE / BOTH |
| 7. GLAUCOMA | | | **(L)** EYE / **(R)** EYE / BOTH |
| 8. DIMINISHED HEARING, DIZZINESS, HOARSENESS | | | **(L)** EAR / **(R)** EAR / BOTH |
| 9. SINUS PROBLEMS OR NASAL POLYPS | | | |
| 10. COUGH, SHORTNESS OF BREATH, WHEEZING, ASTHMA | | | |
| 11. COUGHING UP SPUTUM OR BLOOD | | | |
| 12. CHEST PAIN, PRESSURE, IRREGULAR HEART BEATS | | | |
| 14. WAKING UP AT NIGHT WITH SHORTNESS OF BREATH | | | |
| 15. ABNORMAL SWELLING OF LIMBS | | | |
| 16. DIFFICULTY WITH SWALLOWING, HEARTBURN | | | |
| 17. NAUSEA, VOMITING, STOMACH TROUBLE | | | |
| 18. CONSTIPATION, DIARRHEA, BLOOD, CHANGES IN BOWEL MVMTS | | | |
| 19. FEVER WITHIN THE LAST MONTH | | | |
| 20. ENLARGED GLANDS/ LYMPH NODES | | | |
| 21. EXPERIENCING AN UNUSUALLY STRESSFUL SITUATION | | | |
| 22. WEIGHT GAIN OR LOSS (± 10 LBS) WITHIN 6 MONTHS? | | | |
| 23. DO YOU SNORE? | | | |

**TURN PAGE OVER**

PATIENT NAME: _____ D. O. B. _____

| SYMPTOMS | YES | NO | EXPLAIN |
|---|---|---|---|
| 24. CANCER | | | TYPE: |
| 25. STROKE / TIA | | | |
| 26. THYROID DISEASE | | | |
| 27. HEART DISEASE | | | TYPE: |
| 28. LUNG DISEASE (ASTHMA, COPD, VALLEY FEVER, EMPHYSEMA) | | | TYPE: |
| 29. LIVER DISEASE | | | TYPE : |
| 30. BLOOD PROBLEMS/ ANEMIA/ CLOTS/ DVT | | | |
| 31. HEAD/ BRAIN PROBLEMS ( **NOT** HEADACHES/ MIGRAINES) | | | |
| 32. **MALES:** PROSTATE/ TESTES/ VASECTOMY | | | |
| **** FEMALE PATIENTS ONLY **** | | | **** FEMALE PATIENTS ONLY **** |
| 33. HAVE YOU EXPERIENCED MENOPAUSE OR A HYSTERECTOMY? | | | |
| 34. ARE YOU PREGNANT AT THIS TIME? | | | |
| 35. ARE YOU TRYING TO CONCEIVE AT THIS TIME? | | | |
| 36. BREASTS/UTERUS/TUBES/ OVARIES | | | |

## PATIENT PAST MEDICAL HISTORY: (CIRCLE) ALL THAT APPLY

| HAVE YOU EVER HAD THE FOLLOWING: | YES | NO | PROVIDE AN EXPLANATION |
|---|---|---|---|
| 1. ABNORMAL CHEST X-RAY | | | |
| 2. ANESTHESIA COMPLICATIONS | | | |
| 3. ANXIETY, DEPRESSION, MENTAL ILLNESS | | | |
| 4. BLOOD PROBLEMS | | | |
| 5. DIABETES | | | TYPE 1 TYPE 2 |
| 6. HEPATITIS | | | **A** **B** **C** |
| 7. HIGH BLOOD PRESSURE | | | |
| 8. HIGH CHOLESTEROL OR TRIGLYCERIDES | | | |
| 9. SEXUALLY TRANSMITTED DISEASE | | | |
| 10. STROKE OR TIA | | | |
| 11. TUBERCULOSIS OR (+) TUBERCULIN SKIN TEST | | | |
| 12. HAVE YOU BEEN EXPOSED TO OR ARE YOU CURRENTLY BEING TREATED FOR AN INFECTIOUS DISEASE? | | | EX: HIV EBOLA OTHER: |

**PLEASE CHECK IF YOU / THE PATIENT HAVE EVER HAD ANY OF THE FOLLOWING MEDICAL CONDITIONS/ SURGERIES. PLEASE PROVIDE DATES OF ANY SURGERIES AND AN EXPLANATION IF NEEDED. PLEASE (CIRCLE) THE SURGERIES YOU HAVE EXPERIENCED WHEN MULTIPLE ARE LISTED.**

| | YES | NO | PROVIDE AN EXPLANATION |
|---|---|---|---|
| 1. EYES (CATARACTS) | | | **(L)** EYE / **(R)** EYE / BOTH |
| (GLAUCOMA) | | | **(L)** EYE / **(R)** EYE / BOTH |
| 2. EARS (PE TUBES) | | | **(L)** EAR / **(R)** EAR / BOTH |
| 3. NOSE (ADENOIDECTOMY) | | | |
| 4. TONSILS | | | |
| 5. HEART VALVE/ ABNORMAL HEART RHYTHM | | | |
| 6. CORONARY (HEART) ARTERIES (ANGINA) | | | |
| 7. ARTERIES (AORTA/ ARMS/ LEGS ) | | | |
| 8. ESOPHAGUS | | | |
| 9. BOWEL (COLITIS) OR APPENDECTOMY | | | |
| 10. GALLBLADDER (STONES) OR (CHOLECYSTECTOMY) | | | |
| 11. PANCREAS | | | |
| 12. HERNIA | | | |
| 13. LYMPH NODES | | | |
| 37. SPLEEN | | | |
| 38. KIDNEY | | | |
| 39. BLADDER | | | |
| 40. HEADACHES/ MIGRAINES/ SEIZURES | | | |
| 41. SKIN | | | |
| 42. SINUS SURGERY (DEVIATED SEPTUM OR RECONSTRUCTION) | | | |
| 43. AUTOIMMUNE DISEASE | | | LUPUS IMMUNODEFICIENCY (EX: IgG IgA) |

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PATIENT NAME: _____ D. O. B. _____

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If the patient is older than 13 years old, skip to **Social History** section.

## PEDIATRIC HISTORY: PLEASE ANSWER THESE QUESTIONS IF THE PATIENT IS UNDER 13 YEARS OLD.

CURRENT GRADE LEVEL: DAY CARE PRESCHOOL ELEMENTARY JR.HIGH

HOW MANY DAYS OF SCHOOL MISSED DUE TO ILLNESS? NONE 1-5 6-10 10-15 15+

1. WAS YOUR CHILD ADOPTED? **YES** **NO**

2. PREGNANCY: FULL TERM PRETERM BIRTH WEIGHT: _____
3. WAS THERE ANY COMPLICATIONS DURING THE PREGNANCY? **YES** **NO** DESCRIBE: _____
4. WERE THERE ANY COMPLICATIONS DURING LABOR/ DELIVERY? **YES** **NO** DESCRIBE: _____
5. WAS THERE ANY COMPLCATIONS WITH GROWTH / DEVELOPMENT? **YES** **NO** DESCRIBE: _____

6. IS THERE A HISTORY OF RSV INFECTION? **YES** **NO**

IS THERE REGULAR CONTACT WITH SOMEONE WHO SMOKES OR EXPOSURE TO SECOND-HAND SMOKE? **YES** **NO**
** IF "YES" (CIRCLE) **ALL THAT APPLY:** NONE MOTHER FATHER GRANDMOTHER GRANDFATHER BABYSITTER OTHER:_____

ARE ALL IMMUNIZATIONS UP TO DATE? **YES** **NO**

***IF CHECKED NO, PLEASE (CIRCLE) WHICH IMMUNIZATIONS ARE NEEDED.***

MMR (MEASLES, MUMPS, RUBELLA) POLIO HPV INFLUENZA

PNEUMOCOCCAL HEPATITIS A/ B VARICELLA TETANUS/ DIPHTHERIA MENINGOCOCCAL (SERIES)

***** IF AT DAYCARE/ BABYSITTER:** IS THERE EXPOSURE TO: ANIMALS TOBACCO SMOKE FROM FIREPLACE SECOND-HAND SMOKE

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## SOCIAL HISTORY: (CIRCLE) ALL THAT APPLY FOR THE PATIENT

**MARITAL STATUS:** MARRIED DIVORCED SEPERATED WIDOWED SINGLE STUDENT CHILD OTHER :_____

**CURRENT EMPLOYMENT STATUS:** EMPLOYED UNEMPLOYED RETIRED HOMEMAKER STUDENT OTHER: _____

**OCCUPATION(S):** _____

**DO YOU HAVE EXPOSURE TO SECOND-HAND SMOKE? YES NO** *IF **"YES"** WHERE AT? HOME WORK OTHER:* _____

**ARE YOU DISABLED? YES NO** PLEASE DESCRIBE: _____

**HAVE YOU EVER BEEN PHYSICALLY, SEXUALLY, OR EMOTIONALLY ABUSED? YES NO** _____

**DO YOU HAVE REGULAR PHYSICAL ACTIVITY? YES NO** TYPE: _____

HAVE YOU EVER USED ANY OF THE FOLLOWING SUBSTANCES?

| SUBSTANCE | CURRENT? | PREVIOUS? | TYPE | AMOUNT | FREQUNECY | HOW LONG | YEAR QUIT |
|---|---|---|---|---|---|---|---|
| TOBACCO | Y N | Y N | | | | | |
| ALCOHOL | Y N | Y N | | | | | |
| CAFFEINE | Y N | Y N | | | | | |
| RECREATIONAL DRUGS | Y N | Y N | | | | | |
| MEDICAL MARIJUANA | Y N | Y N | | | | | |

ARE YOU **CURRENTLY** ATTENDING SCHOOL? **YES / NO** JR. HIGH HIGH SCHOOL COLLEGE TRADE SCHOOL:_____

CURRENT GRADE LEVEL:_____ # OF SCHOOL/WORK DAYS MISSED DUE TO ILLNESS: _____ ARE YOU WORSE AT SCHOOL? **YES** **NO**

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PATIENT NAME: _____ D. O. B. _____

## ENVIRONMENTAL HISTORY: (CIRCLE) ALL THAT APPLY.

CURRENT RESIDENCE: FLAGSTAFF SEDONA PRESCOTT OTHER: _____ HOW LONG? _____
PREVIOUS LOCATIONS: _____

**RESIDENT TYPE** HOUSE CONDO/TOWN HOME APARTMENT MOBILE HOME STUDIO OTHER: _____

**LANDSCAPING** GRASS/ TREES/ WEEDS GRAVEL/ ROCK/ DIRT/ SAND OTHER:_____

**NEIGHBORHOOD** RESIDENTIAL RURAL AGRICULTURAL INDUSTRIAL BUSINESS OTHER: _____

**HEATING** GAS ELECTRIC WOOD STOVE NONE OTHER: _____

**COOLING** CENTRAL AIR CONDITIONING SWAMP COOLER NONE OTHER: _____

**ALLERGEN/AIR FILTER** SMALL BEDSIDE ELECTRIC HEPA NONE OTHER: _____

**BEDROOM** CARPET TILE HARD WOOD LINOLEUM/ LAMINATE AREA RUGS CONCRETE OTHER: _____

**BED TYPE** BOX SPRING WATERBED BUNK BED FUTON TEMPURPEDIC SLEEP NUMBER OTHER: _____

**PILLOWS** POLYESTER FOAM FEATHER NONE OTHER: _____

**ANIMAL EXPOSURE: MARK ALL THAT APPLY**. *IF "OTHER" IS CHECKED,* **PLEASE WRITE WHAT KIND OF ANIMAL** *IN THE "OTHER" BOX.*

| CAT | DOG | HORSE | RABBIT | GERBIL | BIRD | OTHER | |
|---|---|---|---|---|---|---|---|
| #: | #: | #: | #: | #: | #: | TYPE: | #: |

## FAMILY HISTORY:

PLEASE SPECIFY IF EACH PERSON IN YOUR BIOLOGIOCAL FAMILY HAS EITHER **SEASONAL ALLERGIES, FOOD ALLERGIES, OR ASTHMA.**

**ARE YOU ADOPTED?** **YES/ NO**
**ARE YOU CURRENTLY A FOSTER CHILD?** **YES/ NO**

** ***Please provide as much information as possible regarding biological relatives if either question was marked "YES".***

*** **PLEASE NOTE: HUSBAND AND WIFE ARE NOT APPLICABLE FOR THIS SECTION!** ***

**IF ANY OF THESE SECTIONS RELATE TO YOUR FAMILY MEMBERS, PLEASE (CIRCLE) EACH INDIVIDUAL FAMILY MEMBER (EITHER MOTHER, FATHER, BROTHER, SISTER, OR OTHER RELATIVES { I.E. GRANDMOTHER OR GRANDFATHER}) WITHIN THE CORRESPONDING SECTION.**
**IF NONE OF THESE APPLY TO YOUR BIOLOGICAL FAMILY, PLEASE (CIRCLE) "NONE" IN EACH SECTION.**

| SEASONAL ALLERGIES | FOOD ALLERGIES | ASTHMA |
|---|---|---|
| MOTHER FATHER BROTHER SISTER | MOTHER FATHER BROTHER SISTER | MOTHER FATHER BROTHER SISTER |
| OTHER RELATIVES:_____ **NONE** | OTHER RELATIVES:_____ **NONE** | OTHER RELATIVES:_____ **NONE** |

### *PRIOR ALLERGIC REACTIONS:*

☐ I / THE PATIENT **DO NOT** HAVE ANY KNOWN DRUG OR FOOD ALLERGIES. ☐ I/ THE PATIENT HAVE NOT HAD ANY TYPE OF INSECT REACTION.
** IF BOXES ARE LEFT UNCHECKED, PLEASE FILL IN ALL INFORMATION BELOW.**

1. **DRUG REACTIONS:** MEDICATION_____ REACTION_____
   MEDICATION _____ REACTION _____
2. **INSECT REACTION:** INSECT TYPE_____ REACTION _____
   WHEN DID THIS REACTION OCCUR? (WITHIN MINUTES, HOURS, DAYS, ETC.) _____
   **SYMPTOMS:** **TONGUE/ THROAT SWELLING HIVES NAUSEA SHORTNESS OF BREATH WHEEZING LOCAL SWELLING**
3. **FOOD REACTION:** WHAT TYPE OF FOOD CAUSED THE REACTION? _____
   HOW MUCH TIME PASSED BEFORE SYMPTOMS STARTED? _____
   **SYMPTOMS:** **TONGUE/ THROAT SWELLING HIVES NAUSEA VOMITING DIARRHEA SHORTNESS OF BREATH WHEEZING**

**CURRENT MEDICATIONS:** (**INCLUDE EPI-PENS, NOSE SPRAYS, BLOOD PRESSURE MEDICATIONS, ASPIRIN REGIMENS, INHALERS/ BREATHING MACHINES, ETC.**) If you need additional space in order to list all medications, please use another sheet of paper.

NAME OF MEDICATION DOSE HOW OFTEN IS THIS TAKEN?

_____
_____
_____
_____

☐ **I AM/ THE PATIENT IS NOT TAKING ANY MEDICATION OF ANY KIND AT THIS TIME.**

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