

NEW PATIENT HISTORY

AGE: _____
 REFERRING PHYSICIAN _____ PHONE #: () _____ - _____
 REFERRING PHYSICIAN ADDRESS:

REASON FOR TODAY'S VISIT:

DRUG ALLERGIES	REACTION

This questionnaire is divided into sections based on your possible different allergic problems. Please fill out as best you can the sections that apply to your conditions.

- Medication list for everyone to complete.....page 2**
- Hayfever (allergies bothering the eyes, nose or throat)..... page 3-4**
- Food allergies.....page 4**
- Asthma or breathing troubles.....page 4-5**
- Hives/angioedema (allergic type swelling).....page 5-6**
- Bee sting/insect bite reactions or latex reactions.....page 5**
- Eczema/allergic rashes.....page 6**
- General history questions for everyone to complete.....page 6-10**
- Work exposure history (complete if indicated).....page 11**

FORM COMPLETED BY: _____ DATE: _____

Please circle all that apply to your hayfever/allergic rhinitis or allergic eye symptoms.

- | | | | | |
|------------------------|----------------|-------------------------|-----------------|--------------|
| Nasal itching | Sneezing | Post nasal drip | Nose bleeds | |
| Nasal congestion | Nasal drainage | Sore throat | Throat itching | Hoarse voice |
| Ear pain/ pressure | Ear popping | Ear itching | Hearing changes | |
| Fluid behind ears | Ear ringing | Ear drainage | Dizziness | |
| Eye redness | Eye itching | Eyelid swelling | Eye watering | |
| Eye pain | Vision changes | Dark circles under eyes | | |
| Loss of taste or smell | | Headache | | |

If **YES** to any of the above questions, how long have these symptoms been present?

If **YES** to any of the above questions, how often do your symptoms occur (# of times per day, week, etc.,)

Are your symptoms worse at any particular time of the year? (circle one) YES NO

If YES, **Please circle which months are worse,**

- | | | | | | |
|---------|----------|-----------|---------|----------|----------|
| January | February | March | April | May | June |
| July | August | September | October | November | December |

Symptoms are worse: **(Check all that apply)**

- | | | |
|----------------------------------|------------------------------------|---|
| <input type="checkbox"/> At home | <input type="checkbox"/> At school | <input type="checkbox"/> At work |
| <input type="checkbox"/> Indoors | <input type="checkbox"/> Out doors | <input type="checkbox"/> Other Location _____ |

Please **Mark any** of the following that make your **symptoms worse.**

- | | |
|--|---|
| <input type="checkbox"/> Fresh cut grass | <input type="checkbox"/> High pollution days |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Air conditioning |
| <input type="checkbox"/> Damp areas | <input type="checkbox"/> Smoke |
| <input type="checkbox"/> Entering a basement | <input type="checkbox"/> Cats |
| <input type="checkbox"/> House plants | <input type="checkbox"/> Dogs |
| <input type="checkbox"/> Barns/hay | <input type="checkbox"/> Other animals _____ |
| <input type="checkbox"/> Wet weather | <input type="checkbox"/> Soap |
| <input type="checkbox"/> Dry weather | <input type="checkbox"/> Perfumes |
| <input type="checkbox"/> Wind | <input type="checkbox"/> Paint fumes |
| <input type="checkbox"/> Hot day | <input type="checkbox"/> Chemical odors |
| <input type="checkbox"/> Cold day | <input type="checkbox"/> News papers |
| <input type="checkbox"/> Weather change | <input type="checkbox"/> Other strong odors _____ |

What medications have you tried for treatment of you symptoms? Indicate if you think the medication improved your symptoms.

Medication	Result

Have you ever been evaluated by an allergist? (Circle one)	YES	NO
If YES, who was your previous allergist? _____		
Have you ever had allergy skin testing or blood testing done? (Circle one)	YES	NO
If YES, what were the positive reactions? _____		

IF POSSIBLE, PLEASE BRING IN PREVIOUS ALLERGY RECORDS OR HAVE THESE SENT TO OUR OFFICE FOR YOUR VISIT.

Have you ever been treated with allergy shots? (Circle one)	YES	NO
If YES, did the allergy shots help you? (Circle one)	YES	NO
What years were the shots taken? _____		
Did you have any serious reactions to the shots?	YES	NO
If YES, please explain _____		

Have you had any problems after eating certain foods? (Circle one)	YES	NO
If YES, please write down the type of food, and the type of reaction below:		

Food	Reaction

Have you been diagnosed with asthma?	YES	NO
If yes, how often do you use your rescue medicine (for example Albuterol)? _____		

Do you have problems with any of the following:		
COUGH?	YES	NO
COUGHING UP MUCUS OR PHLEGM?	YES	NO
WHEEZING?	YES	NO
SHORTNESS OF BREATH?	YES	NO
At rest? YES NO With activity YES NO		
COUGHING UP BLOOD FROM YOUR LUNGS?	YES	NO

Is your coughing, wheezing or shortness of breath worse at certain times of the year?	YES	NO
If YES, please specify which months. <u>Please circle all that apply.</u>		

- | | | | | |
|---------|----------|----------|-----------|---------|
| January | February | March | April | May |
| June | July | August | September | October |
| | November | December | | |

What seems to trigger your coughing, wheezing or shortness of breath? **Please circle your answer.**

Exposure to:

Cold	Heat	Humidity	Quick weather changes	Smoke
Dust	Mold	Grass	Weeds	Strong odors
Cats	Dogs	Other animals	_____	Physical activity
Upper respiratory infections	Other	_____		

DO YOU HAVE TROUBLE WITH CHEST PAIN?

YES NO

If YES, is it: Sharp Dull Tight Pressure Stabbing

Where is the pain specifically located _____

How long have you had this pain? _____ # days _____ # weeks _____ # years

PULMONARY TEST RESULTS

Have you ever had:

Chest X-ray?	↑ YES	↑ NO	If YES, when? _____	where? _____
Chest CAT scan	↑ YES	↑ NO	If YES, when? _____	where? _____
Breathing test? (PFT)	↑ YES	↑ NO	If YES, when? _____	where? _____
Sleep study?	↑ YES	↑ NO	If YES, when? _____	where? _____
Exercise test?	↑ YES	↑ NO	If YES, when? _____	where? _____

Have you ever had hives, urticaria, welts or problems with swelling of your lips, tongue, throat, hands or feet?

YES NO If YES, please describe:

Have you had any reactions after an insect bite or bee, wasp, yellow jacket, hornet or fire ant sting?

YES NO If YES, please describe:

Have you ever had problems after exposure to latex (gloves, balloons, rubber products, condoms, etc.)?

YES NO If YES, please describe:

Do you have a history of eczema or atopic dermatitis?

YES NO If YES, please describe where you get a rash and what treatment has been tried.

Have you ever had contact dermatitis? (A rash after something touches your skin, such as certain metals or poison ivy)

YES NO If YES, Please describe.

Have you ever had a reaction after an immunization/vaccine?

YES NO If YES, please describe.

PAST MEDICAL HISTORY

Please Circle all that apply to your past or current medical history

- | | | |
|------------------------------------|------------------------------------|------------------------|
| Allergies/hayfever | Endometriosis | Osteoporosis |
| Anemia | Glaucoma | Pleural fluid/effusion |
| Aneurysm | Heart attack | Pneumonia |
| Arthritis | Heartburn/reflux | Polio |
| Asthma/Wheezing | Heart failure Heart valve problems | Prostate problems |
| Back pain-recurrent | Heart valve problems | Psychiatric problems |
| Bleeding tendencies/ bruise easily | Hepatitis/liver disease | Recurring infections |
| Blood clots | Herpes | Rheumatic fever |
| Bronchitis | High blood pressure | Rheumatoid arthritis |
| Cancer, type _____ | High cholesterol | Sinus infections |
| Cataracts | HIV positive or AIDS | Sleep apnea |
| Chest injury | Irregular heart beat | Skin infections |
| Collapsed lung | Kidney disease | Stomach ulcers |
| Convulsions/Seizures | Lupus | Thyroid disease |
| COPD/Emphysema/chronic bronchitis | Meningitis/brain infection | Stroke |
| Cystic Fibrosis | Migraine headaches | Tuberculosis (TB) |
| Depression | Neurological problems | Ulcers |
| Diabetes | Nasal or sinus polyps | Varicose veins |
| Difficulty swallowing | | Venereal disease |

Have you ever been on a ventilator (life support breathing machine)

YES NO

If YES, when and for what? _____

Do you have other conditions requiring regular medical attention ?

Problem	Year

GASTROINTESTINAL / LIVER:

Nausea Vomiting Vomiting blood Abdominal pain Bloody stool Constipation
Black, tarry stool Diarrhea Hemorrhoids Heartburn/ GERD
Hepatitis / jaundice (yellowing of eyes) Pain with swallowing Difficulty swallowing

RENAL / URINARY:

Painful urination Burning urination Bloody urine Frequency
Nighttime urination Decreased stream Hesitancy Incontinence

MUSCULOSKELETAL:

Arthritis Joint deformity Joint stiffness/swelling Muscle ache

NEUROLOGICAL:

Double vision Seizures Numbness/tingling Lightheadedness weakness
Paralysis Hearing changes Slurred speech

PSYCHOLOGICAL:

Anxiety Depression Personality change Poor concentration
Memory change Suicidal thoughts

MALE GENITAL-REPRODUCTIVE:

Erectile dysfunction Infertility Infection Mass Pain

FEMALE GENITAL-REPRODUCTIVE:

Abnormal bleeding Menopause Infection Irregular periods
Infertility Abnormal pap

YOUR SOCIAL HISTORY AND HABITS

Have you ever used any of the following?

↑ Cigarettes _____ packs/day _____ # of years.

↑ Pipe _____ hours/day _____ # of years.

↑ Cigars _____ number/day _____ # of years.

↑ Chewing tobacco

↑ Snuff

Are you currently smoking? ↑ YES ↑ NO If previous smoker, year quit? _____

Interested in stopping? ↑ YES ↑ NO

Have you had significant exposure to other people smoking cigarettes? ↑ YES ↑ NO

If YES, who, how much and for how long?

↑ Alcohol: Type: _____ Amount: _____ How often _____

↑ Street drugs: (including Cocaine, Marijuana, Heroin or Meth)

What: _____ When: _____ How often _____

Marital Status: Married Single Divorced Widowed Other

Occupation _____

Any work exposure to asbestos, hard rock mining, factory, flour, chemicals, welding etc.? ↑ YES ↑ NO

If YES, what : _____ When: _____

Have you ever lived outside of Montana? ↑ YES ↑ NO

If YES, where: _____ when: _____

how long _____

FAMILY MEDICAL HISTORY
(check all that apply)

	Father	Mother	Children	Brother	Sister	Other blood relative
Allergies/ Hay fever						
Angioedema (allergic swelling)						
Arthritis						
Asthma						
Bleeding disorder						
Blood clots						
Cancer						
Cystic fibrosis						
COPD/Emphysema/Chronic bronchitis						
Diabetes						
Eczema						
Heart disease						
High blood pressure						
Hives (Uticaria)						
Immunodeficiency (recurrent infections)						
Interstitial lung disease						
Kidney disease						
Lupus						
Pulmonary fibrosis						
Rheumatoid arthritis						
Stroke						
Other:						

This next section should be filled out as completely as possible to help your physicians better assess your condition. This portion will tell us about other possible areas which could be causing you discomfort.

In what type of dwelling do you live? Please **circle** your answer.

- | | | |
|-----------|------------|-------------|
| House | Town house | Condominium |
| Apartment | Flat | Mobil home |

What is the age of your dwelling? _____ years old

How long have you lived there? _____ years _____ months

Circle the one best answer: Your dwelling is built over:

- | | | |
|------------------------------------|------------------------------------|-----------------|
| A crawl space | A cement slab | A full basement |
| A partial basement and crawl space | A partial basement and cement slab | |

Describe the basement or crawl space: **Circle more than one if applicable.**

- | | | |
|----------------------------------|----------------------|--------------------|
| Wet | Has a musty odor | Has a cement floor |
| Dry | Never musty | Has a tiled floor |
| Sometimes wet or damp | Has a carpeted floor | |
| Is covered with plastic sheeting | | |

What type of fuel do you use for heating? **Circle more than one if applicable.**

- | | | | |
|-------------|----------|------|----------|
| Natural gas | Electric | Wood | Fuel oil |
|-------------|----------|------|----------|

What type of heat system does your home have? **Please circle you answer.**

Forced air Baseboard hot water Steam radiators Central stove or heater
 Electric radiators or heater Heat pump

Please **circle any** of the following that you use in your home:

Central air conditioning Room air conditioning Swamp cooler Ceiling fans
 Window fans Dehumidifier Humidifier (central/portable)
 Steam vaporizer Cool mist vaporizer Central air cleaner Room air cleaner

How many house plants are in the home? _____

How many arrangements of dried flowers are there in the home? _____

Where does mildew or mold (usually black) tend to appear? **Circle any that apply**

Have never seen any Bathroom grout Basement Bathroom shower curtain
 Closets Elsewhere in the bathroom Laundry area
 Other rooms _____

Have you ever seen any cockroaches in your home? YES NO

Do you have any pets in your home? **Please circle all that apply** and indicate how many you have, and how long you have had the pet in your home.

Pet	How many	How long	Hours/day spent in the home
Cats			
Dogs			
Birds			
Hamsters			
Guinea pigs			
Gerbils			
Rats			
Mice			
Rabbits			

Other animal exposure (indoor or outdoor):

What type of pillow is used? **Circle the one best answer.**

Foam Dacron Feather Other synthetic

Is the pillow encased in a plastic/special dust mite protective material? YES NO

Is the mattress encased in a plastic/special dust mite protective material? YES NO

Are the box springs encased in a plastic/ special dust mite protective material? YES NO

OCCUPATIONAL EXPOSURE
(Complete only if your symptoms are related to work exposure)

Employers name: _____ Job title: _____

Date job began: _____ Date job ended: _____ Duration: _____

Industrial process: _____

Describe job activity

List materials used:

Estimate of intensity of exposure: SLIGHT MODERATE GREAT

Explain: _____

Was respiratory protection used? All the time Sometimes Rarely Never

List materials used by adjacent workers:

Estimate of ventilation/exhaust status Good Fair Poor

Explain: _____

Part-time jobs/ hobbies: YES NO

Explain: _____

CLINICAL INFORMATION

Any symptoms related to above? YES NO

Explain: _____

Time interval between job began and symptoms developed: _____

Relationship between work and symptoms? YES NO

Explain: _____

Time off work due to illness: YES NO

Number of days off: _____

Explain: _____

Other workers affected? YES NO

Explain: _____

Exams before employment and / or while working? YES NO

Explain: _____
