Allergy, Asthma & Immunology Center of Alaska, LLC

Please fill out fully (circle, check and / or fill in the answer)

Name ______________________________ Age_____ DOB _________ M/F___ Date ____________________
Referred by? ______________________ Additional Physicians____
Reason for visit:____
Local pharmacy of choice:________________________ Mail order pharmacy:___________________________

Circle or check symptoms that apply, or circle none:

UPPER AIRWAY SYMPTOMS

Rhinitis (nose)
None
Itchy nose
Sneezing
Runny nose
Post nasal drip
Throat clearing
Nasal congestion
Constant “cold” like symptoms
Dry nasal membranes
Diagnosed nasal polyps
Loss of taste
Loss of smell
Itchy roof of mouth
Sensitivity to odors

Conjunctivitis (eyes)
None
Itchy eyes
Watery eyes
Red eyes

Sinusitis (sinuses)
None
Sinus pressure
Sinus pain
Upper teeth hurting
Headaches
Bad breath
Cheek pain
Forehead pain

Symptoms occur:
Spring
Summer
Fall
Winter
All year
With weather changes
Randomly

Symptoms began (how many?)
_____ Days ago
_____ Weeks ago
_____Months ago
_____Years ago

Prior nasal or sinus surgery:
None
Adenoidectomy
Tonsillectomy
Ear tubes (PETs)
Other ____________________________
Sinus irrigation
Nasal polyp removal
Nasal foreign body removal
Sinus surgery

Prior treatments (allergy and sinus):
None
Steam inhalation
Allergy shots
Nasal saline washes
Oral allergy medications (Zyrtec, Claritin, etc)
Pain relievers (Tylenol, Motrin)
Decongestant nasal sprays (Afrin)
Other ____________________________
Oral decongestants (Sudafed)
Steroid nasal spray (Flonase, Nasonex, etc)
Leukotriene Receptor Antagonists (Singulair)
Allergy eye drops (Pataday, Bepreve)
Oral steroid (Prednisone, Orapred)
Oral antibiotics
IV antibiotics

Revised 01/2013

Please fill out fully (circle, check and / or fill in the answer)

Prior allergy shots:
Is currently receiving allergy shots
Is not currently receiving allergy shots
Received allergy shots in the past but stopped
Is interested in receiving allergy shots
May be interested in receiving allergy shots
Is not interested in receiving allergy shots

Circle any of the following that aggravate your problem
House dust
Vacuuming
Sweeping
Hay/Straw
Mowing the lawn
Barn/Stable/Silo
Basement
Raking leaves
Pollens (grass, trees, weeds)
Exposure to Chemicals
Wood stove
Tobacco smoke
Strong odors
Cold air
Humidity
Exercise
Dogs
Cats
Birds
Other animals _____________________
Other triggers _____________________

LOWER AIRWAY SYMPTOMS

Symptoms:
No lower airway symptoms
Chronic cough
Night time cough
Recurrent wheezing
Shortness of breath
Chest tightness
Recurrent bronchitis
Shortness of breath with exertion/exercise
Cough with exertion/exercise
Wheezing with exertion/exercise
Have you been previously diagnosed with asthma? Y/N

Symptoms began (how many?)
_____ Days ago
_____ Weeks ago
_____Months ago
_____Years ago

Prior treatment for lower airway:
None
Albuterol inhaler or nebulizer
Inhaled steroids (Flovent, QVAR, etc)
Combination ICS/LABA (Advair, Symbicort, etc)
Leukotriene Receptor Antagonists (Singulair)
Oral steroids (Prednisone)
Other asthma medications: _______________________

Current symptom frequency:
Daily
Weekly
Monthly
Less than monthly
Days/week with daytime symptoms _______
Days/month with nighttime symptoms _______

Albuterol Usage:
# of times a day_____, or # of times a week _____,
Or # of times a month ______

Asthma history (if previously diagnosed with asthma):
Have you ever had (circle all that apply):
Frequent ER visits
Prior oral steroid bursts
Prior hospitalizations
Prior ICU admission
Prior intubation

Please fill out fully (circle, check and / or fill in the answer)

GASTROINTESTINAL PROBLEMS/FOOD ALLERGIES

Any known or suspected food allergies? Y/N If Yes, list suspected foods:____
____

Food allergy symptoms:

Hives with foods
Eczema flare with foods
Swelling with foods
Mouth itching
Bloating
Bloody stools
Constipation
Diarrhea
Other: ___________________________________
Throat tightness
Trouble breathing
Wheezing
Abdominal pain
Difficulty swallowing
GERD/Heartburn
Nausea
Vomiting

Symptoms began (how many?)

_____ Weeks ago
_____Months ago
_____Years ago

Pattern of symptoms

Intermittent
Persistent

Severity of symptoms:

Mild
Moderate
Severe

SKIN PROBLEMS

Symptoms:

Hives
Eczema
Dry skin
Swelling
Itchy skin
Other skin rash

How often do you bathe/shower? ________________________
How often do you use moisturizer? _______________________
Do you use liquid fabric softener? Y/N
Do you use dryer sheets? Y/N
Soap Brand _____________________________
Moisturizer Brand________________________
Detergent Brand ________________________

Location of skin problems:

Face
Trunk
Legs
Head
Other____
Hands
Arms
Feet
Neck

Severity of symptoms:

Mild
Moderate
Severe
Waxing and Waning

Please fill out fully (circle, check and / or fill in the answer)

SEVERE ALLERGIC REACTIONS

Have you ever had a life threatening allergic reaction? Y/N (If Yes, please complete details below)

Symptoms:

Rash
Itching
Swelling
Facial swelling
Itchy throat
Difficulty swallowing
Lip swelling
Sneezing
Runny nose
Itchy nose
Coughing
Hoarseness
Wheezing
Shortness of breath

What triggered the reaction?

Unknown
Ingestion of a specific food __________________________
Taking a medication _______________________________
An allergy shot
A vaccination ____________________________
An insect sting or bite
Animal exposure
Other ________________________________

Severity of symptoms:

Mild
Moderate
Severe

RECURRENT INFECTIONS

None
Recurrent ear infections? Y/N If Yes, how many per year?_____ Ear tubes required? _____
Recurrent sinusitis infections? Y/N If Yes, how many per year? ____________
Recurrent pneumonias? Y/N If Yes, how many? ________________
Recurrent skin infections? Y/N
Other concerning infections? (meningitis, cellulitis, abscesses, etc)?____

MEDICATIONS

Any medication allergies Y/N If Yes, please list : ____
List medications taken for asthma, allergies, sinus, or skin problems. Include nasal sprays.

Present allergy/asthma medications

_________________________________ helpful/ not
_________________________________ helpful/ not
_________________________________ helpful/ not
_________________________________ helpful/ not
_________________________________ helpful/ not

List **ALL** other medications presently taken for other conditions.

_________________________________ For medical condition: ____________________________________
_________________________________ For medical condition: ____________________________________
_________________________________ For medical condition: ____________________________________
_________________________________ For medical condition: ____________________________________
_________________________________ For medical condition: ____________________________________

YOU MAY SKIP THE REMAINDER OF THIS FORM IF YOU COMPLETED THE ONLINE HEALTH HISTORY INFORMATION

 Revised 01/2013

Please fill out fully (circle, check and / or fill in the answer)

REVIEW OF SYSTEMS

-Circle ALL symptoms that apply

General:
Unexplained weight gain
Unexplained weight loss
Unexplained fever

Neck:
Neck mass
Swollen glands

Gastrointestinal:
Abdominal pain
Bloody stools
Constipation
Diarrhea
Difficulty swallowing
Frequent belching
Gas
Heartburn
Indigestion
Mucosy stools
Nausea
Vomiting

HEENT:
Bad taste
Loss of taste
Loss of smell
Sore throat
Voice changes

Respiratory:
Snoring
Shortness of breath

Cardiovascular:
Chest pain

Musculoskeletal:
Joint pain
Muscle pain

Neurological:
Headaches

Endocrine:
Appetite changes
Thyroid problems

PAST MEDICAL HISTORY

List all other medical conditions briefly :____
____

PAST SURGICAL HISTORY

List prior surgeries (with approximate dates) :____
____

BIRTH HISTORY/ INFANT FEEDING

Gestational Age:
Term (37-42 weeks)
Pre Term (<37 weeks)
Post Term (>42 weeks)
Complications?:________________________________

Delivery Mode:
Natural
C-Section

Feeding History:
Breast Fed? Y/N How many months? _________
If formula fed/supplemented, what formula base: (circle one)
Milk based
Soy based
Hydrosylated
Other:________________

OTHER ALLERGIES

Latex allergies Y/N If Yes, please list : ____
Contact allergies Y/N If Yes, please list: ____

Insects
None
Yellow jacket
Bee
Wasp
Fire Ant
Mosquito
Other stinging insect:________
Other biting insect:________

Please fill out fully (circle, check and / or fill in the answer)

Food Allergies

Cow's milk	Tree nuts
Egg	Fish
Wheat	Shellfish
Peanut	Other:____________
Soy	

SOCIAL/ ENVIRONMENTAL HISTORY

Home type:	House	Apartment	Mobile Home	Condo/Townhome		
Home location:	Country	Near a lake	Wooded Area	Farm	City	
Home heating:	Forced air	Wood stove	Fireplace	Propane/Fuel	Baseboard	Radiant floor
HEPA Air Cleaner:	None	Central	Room			
Humidifier:	None	Central	Room			
Carpeting:	None	Throughout	Bedroom	Other rooms		
Basement:	None	Unfinished	Finished	Carpeted		
Indoor pets/animals:	None	Dog	Cat	Bird	Fish	Gerbil
	Hamster	Rabbit	Reptile	Rodent	Other: ______________	
Bedding:	Regular Mattress	Waterbed	Feather pillow	Fiber pillow	Foam pillow	
	Hypo allergenic mattress case		Hypo allergenic pillow case			
Stuffed Animals:	Yes	No				
Window treatments:	Drapes	Blinds	Shades			

Occupation: ____

Hobbies: ____

Smoking History: ______ Nonsmoker _____ Smoker

If you are a smoker please fill/circle the questions below:

Tobacco use: ______________ years

Smokes Cigarettes? Y/N If yes, How many packs per day?________

Smokes Pipe? Y/N	Uses Chewing tobacco? Y/N
Smokes Cigars? Y/N	Uses Snuff? Y/N

Have you?

Recently quit?	Remotely quit?
If yes, how long did you smoke? ________________	When did you quit? _________________
Would you like to quit? Y/N	Have you tried to quit? Y/N

Second Hand tobacco exposure:

None	Minimal
Frequent	Daily
Family member smokes indoors/in car	Family member smokes outdoors only
Caregiver smokes indoors/in car	Caregiver smokes outdoors only

FAMILY HISTORY

Do parents (m,f), grandparents (gm, gf), siblings (b,s), or children (d, son) have the following?

Arthritis ____________________________	Alpha-1-antitrypsin deficiency__________	Asthma____________________________
Chronic Infections___________________	Contact Dermatitis___________________	Cystic Fibrosis______________________
Eczema____________________________	Emphysema_________________________	Food Allergy________________________
Hay fever/allergic rhinitis _____________	Hives______________________________	Lupus______________________________
Sinusitis___________________________	Thyroid Disease_____________________	

IMMUNIZATION HISTORY

Are immunizations/vaccines up to date? Y/N/Not Sure :____

TRAVEL HISTORY

Any recent or unusual travel? (out of state or country):____