ADULT PATIENT HISTORY Date of Initial Visit _____

Confidential record; Information contained here will not be released except when you have authorized us to do so.

Last_____First_____Middle_____Birth date _____Age_____ Birth Place_____

Address_____City_____State_____Zip Code_____ Phone_____

Occupation_____ Spouse Occupation_____

Sex: Female Male **Marital Status**: Married Single Widow Divorce Separated **Religion:** _____

Emergency Contact Person _____Relationship _____Phone # _____

Referring Physician _____Address_____Phone # _____

Primary Care Physician _____Address_____Phone # _____

Date of last OB GYN Exam _____ Doctor _____ Town _____

Date of last Physical Exam _____ Doctor _____ Town _____

I would like a report of this consultation sent to doctor _____

Have you ever been diagnosed with an Auto Immune Disease?_____Date_____

What is your Chief Complaint _____

What age did your symptoms start _____

Circle "Yes" or "No" with you answer to questions below

Yes	No	Do you frequently have severe headaches?
Yes	No	Do they occur only on one side of the head? Which side? Right or Left
Yes	No	Do they awaken you at night from sleep?
Yes	No	Do they hurt most in the front of the head and neck?
Yes	No	Do they hurt most in the front of the head, forehead, or sinus area?
Yes	No	Does aspirin relieve them?
Yes	No	Do you frequently have excess tears in your eyes?
Yes	No	Do you have frequent earaches?
Yes	No	Have you ever had a punctured ear drum or draining ear?
Yes	No	Do you now have decreased hearing?
Yes	No	Are you frequently hoarse?
Yes	No	Do you frequently get sore throats?
Yes	No	Do you frequently have stuffy nose?
Yes	No	Do you frequently have mucus in the back of your throat?
Yes	No	Have you ever had nasal polyps?
Yes	No	Do you wake up in the middle of the night short of breath?
Yes	No	Do you wake up coughing first, then wheeze?
Yes	No	Do you cough up mucus or phlegm on arising almost every morning?
_____ times		How many times have you had pneumonia?
Yes	No	Have you had chills or fever with your breathing problem?
Yes	No	Have you ever had pleurisy?
Yes	No	Have you ever coughed up blood?

Do/did your Parents, grandparents, bothers, or sisters have any of the following (write the in relationship on the line below)

Asthma_____
Hay-fever_____Hives_____

Eczema_____ Bee sting allergy_____

SEASONALITY: Select the following boxes as follows: No symptoms = 0 Any symptoms = + Severe symptoms = ++

***Example below**: If you have hay fever but no asthma, hives, eczema or arthritis each Fall only, at home and at work and no symptoms in the winter, your answer might look this:*

Circle your symptom below	Age Began	Summer	Winter	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Home	Work
Asthma																	
Nasal: Congested nose, Itchy eyes Sneezing, Frequent colds	12	+	0								+	++	+			+	+
Hives																	

Circle your symptom below	Age Began	Summer	Winter	Jan	Feb	Mar	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Home	Work
Asthma																	
Nasal: Congested nose, Itchy eyes Sneezing, Frequent colds																	
Hives																	
Eczema																	
Arthritis																	

ENVIRONMENT

Type of heat at home	_____Hot air	_____Hot water	_____Electric	_____Wood burning stove	_____Space heater
Type of heat at work	_____Hot air	_____Hot water	_____Electric	_____Wood burning stove	_____Space heater

Animals or pets at home_____ since when _____Where do they sleep_____
Animals at work_____ Approximate age of your home_____ City_____ Country_____
Pillows are stuffed with_____ Mattress pad stuffed with_____
Type of under padding of rugs _____synthetic _____ animal hair House plants (how many) _____
Hobbies and other activities Indoor_____ Outdoor_____
Do you have a LATEX allergy _____

Put an **X** beside any of the following that have caused you to experience wheezing, coughing, runny nose, nasal congestion or hives.

Dogs	Cats	Horses	Other Animals
Barn	Beer or Wine	Gardening	Basement/cellar
Hair spray	Wool	Rain	Insect spray
Air conditioning	Cosmetics	Perfumes	After shave lotion
Dust	Drafts	Humidity	After a bath/shower
Tobacco smoke	Strong odor	Alcoholic beverages	Fatigue
Anything at work	Rapid change in temperature	Hot water	Cold weather

FOOD AND MEDICATION ALLERGIES

Food to which you have actually had an allergic reaction_____
Reaction _____How long after eating the food did the reaction occur_____
Medications that have caused a bad reaction (rash, swelling, wheezing) Penicillin _____Reaction _____
Tetanus injection_____ Reaction_____ Aspirin _____ Reaction_____
Name any other drugs to which you have had a bad reaction _____Reaction_____

STINGING INSECT ALLERGY

Stinging insect's reaction (bee, hornet, wasp) local swelling only Yes or No?
or if, a big generalized reaction; describe_____

PREVIOUS ALLERGY TESTING AND TREATMENT

Have you been **SKIN** tested for allergies? _____When_____ by whom_____? What reacted _____
_____

Have you ever received injection treatment against allergies? _____ Started when_____ Date of last injection_____
What was in the injection?_____

PREVIOUS STEROID TREATMENT

Have you ever received cortisone medications (Prednisone, Decadron, Medrol, Kenalog, Aristocort, Steroids) by pill or injection? _____
Date of last dose?_____How long did you take them?_____What dose?_____Every day?_____
Every other day?_____Was dose reduced each day?_____
Do you or did you ever have: Diabetes_____Ulcer_____Tuberculosis_____High blood pressure_____

OTHER MEDICATIONS, INHALERS, NOSE SPRAY AND SMOKING

What medications (pills, capsules, injections, liquids, drops, ointments or sprays) have you taken in the past month? Include Aspirin, birth control, etc._____
Do you use a hand spray (mouth) inhaler? _____
When was the last time you used a nose spray or drops? _____
Are you presently taking any of the following medication? (Please circle)

Yes	No	Aspirin, Bufferin, Anacin	Yes	No	Laxatives	Yes	No	Injectable Shots
Yes	No	Blood pressure pills	Yes	No	Sleeping pills	Yes	No	Water pill
Yes	No	Cough medicine	Yes	No	Thyroid medicine	Yes	No	Antibiotic
Yes	No	Digitalis	Yes	No	Tranquilizers	Yes	No	Barbiturates
Yes	No	Hormones	Yes	No	Weight reducing pills	Yes	No	Birth control pills
Yes	No	Insulin or diabetic pills	Yes	No	Blood thinning pills	Yes	No	Phenobarbital
Yes	No	Iron or poor blood medications	Yes	No	Dilantin	Yes	No	Other drugs not listed

EARS, NOSE, THROAT SURGERY Tonsils removed_____ Age_____Ear or nose surgery_____Age_____

FAMILY HISTORY	AGE	IF LIVING HEALTH	AGE OF DEATH	IF DECEASED CAUSE
Father				
Mother				
Brothers/ Sisters				
Spouse				
Sons or Daughters				

PERSONAL HABITS

Yes	No	Are you or have you ever been a smoker? How many years?_____Packs a day?_____Stopped?_____
Yes	No	Do you regularly smoke? Cigarettes _____Pipe_____ Cigars_____ Vaping_____Marijuana_____
Yes	No	How many cups of coffee per day do you drink?
Yes	No	Do you regularly drink alcohol? 1oz per day_____ 2oz per day_____ 4oz per day_____ Over 6oz per day_____
		Beer: 1 bottle per day_____ 2 bottles per day_____ Over 4 bottles a day_____

SURGERY, HOSPITALIZATION AND INJURIES – Write in the name of operation and date

SERIOUS INJURIES OR ACCIDENTS (Not requiring hospitalization) **DATE**

IMMUNIZATIONS

If date(s) unknown, are you up to date, to the best of your knowledge? Yes _____ No_____

	Date		Date		Date		Date
Tetanus		Measles		Smallpox		Last influenza vaccine	
Polio, oral		German Measles		PCV13 or Prevnar 13			

Polio, injection		Tuberculin (PPD)		PPSV23 or Pneumovax 23			