# Initial Patient Medical History

| Name: |
| --- |
| ID Number: |

Patient Name: ____________________

Address: ____________________

City: ____________ State: ________ Zip: ________

Home Phone: ____________ Work Phone: ____________

Age: ______ Date of Birth: ________ Birth State: ____________

Height: ______ Weight: ______ Sex: ❑ Male ❑ Female Married ❑ Yes ❑ No

Insurance Company / HMO Name: ____________________

Employer: ____________________

____________________

**Were you referred to this office by another physician?** ❑ Yes ❑ No

**If you were referred by a physician, what is his or her specialty? (check one)**

❑ Family physician ❑ Allergist ❑ Internist ❑ Pediatrician ❑ Other ____________

**Please give his or her name, address and phone number:**

Physician Name: ____________________

Address: ____________________

City: ____________ State: ________ Zip: ________

Phone Number: ____________ Fax: ____________

**Who is your primary care physician? (Name, address and phone number)**

Physician Name: ____________________

Address: ____________________

City: ____________ State: ________ Zip: ________

Phone Number: ____________ Fax: ____________

**Would you like your asthma evaluation to be sent to your primary care physician?** ❑ Yes ❑ No

**If there are *other* physicians who you wish to receive copies of your evaluation, please list the names, addresses and phone numbers of these physicians below:**

Physician Name: ____________________

Address: ____________________

City: ____________ State: ________ Zip: ________

Phone Number: ____________ Fax: ____________

Physician Name: ____________________

Address: ____________________

City: ____________ State: ________ Zip: ________

Phone Number: ____________ Fax: ____________

Name:

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## Chief Complaint

**Please describe in your own words the primary medical problem which prompted you to seek an evaluation today:**

______________________________

______________________________

**What are your symptoms? (check all that apply)**

- ❑ Cough
- ❑ Wheezing
- ❑ Coughing up blood
- ❑ Sudden attacks of shortness of breath
- ❑ Shortness of breath at rest
- ❑ Shortness of breath with activity
- ❑ Shortness of breath at night
- ❑ Phlegm (i.e., sputum) production
- ❑ Tightness of chest
- ❑ Other

**Please list any concerns you have regarding asthma:**

______________________________

______________________________

______________________________

## Asthma Severity

**CHECK ONE THAT MOST APPLIES**

| | | | | |
|---|---|---|---|---|
| **Symptom frequency** | ❑ <1 x per week | ❑ 2-6 x per week | ❑ Daily | ❑ Always |
| **Nighttime asthma symptom frequency** | ❑ <2 x per month | ❑ 2-4 x per month | ❑ 2-4 x per week | ❑ Almost every night |
| **Do asthma symptoms wake you up at night?** | ❑ Never | ❑ Sometimes | ❑ Usually | ❑ Always |
| **Do you have asthma episodes/attacks after sleep?** | ❑ Never | ❑ Sometimes | ❑ Usually | ❑ Always |
| **Do you have asthma episodes/attacks after physical activity?** | ❑ Never | ❑ Sometimes | ❑ Usually | ❑ Always |
| **Do your symptoms interfere with school or work?** | ❑ Never | ❑ Sometimes | ❑ Usually | ❑ Always |
| **Do your symptoms go away after the use of an inhaler?** | ❑ Yes (Which inhaler? ____________________) | | | ❑ No |
| **How often do you use extra inhaler treatments?** | ❑ Never | ❑ Sometimes | ❑ 2-5 times week | ❑ Every day |
| **Do you have frequent asthma episodes?** | | | ❑ Yes | ❑ No |
| **Do your symptoms ever cause you to stop physical activity?** | | | ❑ Yes | ❑ No |
| **Have your symptoms forced you to change your occupation or quit work?** | | | ❑ Yes | ❑ No |
| **Have your symptoms required frequent trips to the Emergency Room?** | | | ❑ Yes | ❑ No |
| **Have your symptoms resulted in any hospitalizations?** | | | ❑ Yes | ❑ No |
| **Have your symptoms resulted in respiratory arrest, intubation and the use of a mechanical ventilator?** | | | ❑ Yes | ❑ No |

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## Trigger Factors

**Which of the following *trigger factors* cause a worsening of your respiratory condition? (check all that apply)**

- ❑ Bronchitis
- ❑ Colds, influenza
- ❑ Sinus infections
- ❑ Nonsteroidal anti-inflammatory agents (i.e., ibuprofen, naproxen, etc.)
- ❑ Aspirin
- ❑ Exercise
- ❑ Wines, alcoholic beverages
- ❑ Cigarette smoke
- ❑ Perfumes, hair sprays
- ❑ Dogs
- ❑ Cats
- ❑ Laughter
- ❑ Damp, musty area
- ❑ Occupational exposures
- ❑ Weather changes
- ❑ Seasons of the year
- ❑ Pollens (cut grass, wooded areas)
- ❑ Cold air
- ❑ Air pollution
- ❑ House dusting/vacuuming
- ❑ Emotions or stress
- ❑ Menstrual cycles
- ❑ Other animals (specify) ______________________
- ❑ Foods (specify) ______________________
- ❑ Food additives (specify) ______________________
- ❑ Odors (specify) ______________________
- ❑ Other (specify) ______________________

## Respiratory History

**What respiratory diagnosis (if any) have you been given by physicians? (Note: you may have more than 1 diagnosis)**

| DIAGNOSIS | DATE WHEN SYMPTOMS BEGAN | DIAGNOSIS | DATE WHEN SYMPTOMS BEGAN |
|---|---|---|---|
| ❑ None | | ❑ Heart failure | ________ |
| ❑ Asthma | ________ | ❑ Pneumonia | ________ |
| ❑ Asthma, exercise-induced | ________ | ❑ Pulmonary fibrosis | ________ |
| ❑ Bronchiectasis | ________ | ❑ Tuberculosis | ________ |
| ❑ Bronchitis | ________ | ❑ Atypical tuberculosis | ________ |
| ❑ Chronic bronchitis | ________ | ❑ Sleep apnea | ________ |
| ❑ COPD | ________ | ❑ Vocal cord dysfunction | ________ |
| ❑ Emphysema | ________ | ❑ Other ________ | ________ |
| ❑ Interstitial disease | ________ | ❑ Other ________ | ________ |

**When did you first have respiratory symptoms?** month ________________ year ________________

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## Shortness of Breath

**How long can you walk before you have to stop because of shortness of breath?**

❑ <3 min ❑ 5 min ❑ 10 min ❑ 15 min ❑ >15 min

**How many stairs can you climb before you have to stop because of shortness of breath?**

❑ <5 ❑ 10 ❑ 15 ❑ 20 ❑ 25 ❑ 30 ❑ >30

**Do you wake up at night with shortness of breath?** ❑ Yes ❑ No

**Have you experienced:** (check all that apply)

| | | |
|---|---|---|
| Excessive daytime sleepiness? | ❑ Yes | ❑ No |
| Difficulty concentrating during the daytime? | ❑ Yes | ❑ No |
| Loud snoring? | ❑ Yes | ❑ No |
| Restless sleep? | ❑ Yes | ❑ No |
| Headaches in the morning? | ❑ Yes | ❑ No |
| Waking up at night due to your snoring? | ❑ Yes | ❑ No |

## Cough **If you have a *cough,* please describe further:**

Is your cough daily or frequent? ❑ Daily ❑ Frequent

Does your cough wake you up at night? ❑ Yes ❑ No

If yes, times per month? ______________________________

| | | |
|---|---|---|
| Do you have frequent episodes of cough associated with phlegm production? | ❑ Yes | ❑ No |
| Have you coughed on most days, for 3 consecutive months or more? | ❑ Yes | ❑ No |
| Do you cough up blood? | ❑ Yes | ❑ No |
| Do you have indigestion? | ❑ Yes | ❑ No |

For how long have you been bothered by a cough? ______________________________

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### Sinus History

**Do you have any of the following? (check all that apply)**

- ❑ Nasal stuffiness
- ❑ Facial pain
- ❑ Runny nose
- ❑ Bad breath
- ❑ Sinus headaches
- ❑ Nasal discharge
- ❑ Postnasal drip
- ❑ Sinus congestion or pressure
- ❑ Nighttime cough
- ❑ Loss of sense of smell
- ❑ Loss of sense of taste

**Have you been treated with antibiotics for sinusitis?** ❑ Yes ❑ No

**If yes, how often have you been treated in the past year?** ______________________

**Please list medication(s):** ______________________

______________________

______________________

**Have you ever been told you have nasal polyps?** ❑ Yes ❑ No

**Have you ever received sinus CT (CAT scan) or x-rays?** ❑ Yes ❑ No

**Date obtained:** ______________________

**Results:** ______________________

______________________

______________________

**Have you ever had sinus surgery?** ❑ Yes ❑ No

**If yes, date:** ______________________

### Childhood Respiratory History

**Did you have symptoms of asthma as a child?** ❑ Yes ❑ No

**Did you have frequent respiratory infections as a child?** ❑ Yes ❑ No

**Were you exposed to passive cigarette smoke as a child?** ❑ Yes ❑ No

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### Allergy History

Do you have symptoms of hay fever, runny nose, itchy nose, itchy eyes, itchy throat or watery eyes? ❑ Yes ❑ No

If yes, are your symptoms seasonal? ❑ Yes ❑ No

Which seasons? (check all that apply) ❑ Spring ❑ Summer ❑ Fall ❑ Winter

Which months? (check all that apply)

| | | | |
|---|---|---|---|
| ❑ Jan | ❑ Feb | ❑ Mar | ❑ Apr |
| ❑ May | ❑ June | ❑ July | ❑ Aug |
| ❑ Sept | ❑ Oct | ❑ Nov | ❑ Dec |

Have you undergone allergy skin tests? ❑ Yes ❑ No

By whom? ______________________________

What was his/her specialty? ❑ Pediatrician ❑ Ear, Nose & Throat ❑ Allergist ❑ Other

Please list the dates and results of these tests:______________________________

______________________________

Have you received allergy shots? ❑ Yes ❑ No

By whom and their specialty? ______________________________

______________________________

If yes, when did you receive them, and for how long a time? ______________________________

______________________________

______________________________

Do allergy shots help your symptoms? ❑ Yes ❑ No

Do you have any proven or suspected food allergies? ❑ Yes ❑ No

If yes, when did you receive them, and for how long a time? ______________________________

______________________________

______________________________

Do you have any other allergy problems, such as hives, latex sensitivity or insect sting allergies (bee, wasp, yellow jacket, hornet or fire ant)? ❑ Yes ❑ No

If yes, when did you receive them, and for how long a time? ______________________________

______________________________

______________________________

Do you currently have eczema? ❑ Yes ❑ No

Have you had eczema or atopic dermatitis in the past? ❑ Yes ❑ No

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## Medication Allergies

**Please list the names of any medication(s) which have caused you to have an allergic reaction.**

| NAME OF MEDICATION(S) | ALLERGIC REACTION(S) |
|---|---|
| | |
| | |
| | |

## Environmental History

**Do you live in a house, apartment or trailer?** ____________________

**Where is the home located? (check all that apply)** ❑ rural ❑ near factories or industries ❑ city ❑ near a river/stream/ocean

**How old is the home?** ____________ **How long have you lived there?** ____________

**How many people live in the home?** ____________________

**Has there been any water leakage or damage in your home?** ❑ Yes ❑ No

**Do you live in a home made of concrete block framing?** ❑ Yes ❑ No

**Type of heating: (check one)** ❑ forced air ❑ gas ❑ radiant ❑ electric ❑ wood burning ❑ other ____________

**How often are the filters changed?** ____________________

**Do you have an electrostatic air filter?** ❑ Yes ❑ No ❑ Don't know

**Do you have any HEPA filters?** ❑ Yes ❑ No ❑ Don't know

**Do you have air conditioning?** ❑ Yes ❑ No

**Do you have a basement?** ❑ Yes ❑ No **If yes, is it damp?** ❑ Yes ❑ No

**Do you have a fireplace?** ❑ Yes ❑ No **If yes, how often is it used?** ____________

**Do you have a wood burning stove?** ❑ Yes ❑ No **If yes, how often is it used?** ____________

**Check rooms with carpeting:** ❑ bedroom ❑ living room ❑ TV room ❑ other

**Type of pillow or comforter (check all that apply):** ❑ feather ❑ dacron ❑ other

**Do you have pillow and mattress dust-proof encasements?** ❑ Yes ❑ No

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## Environmental History (continued)

How many stuffed toys do you have in your bedroom? ______

Do you have any pets? (check all that apply) ❑ cat ❑ dog ❑ hamster ❑ bird ❑ guinea pig ❑ other

Where do they sleep? ______

Does anyone smoke in your home? ❑ Yes ❑ No

## Smoking History

Have you ever smoked cigarettes? ❑ Yes ❑ No

If yes, how old were you when you started smoking? ______

Are you still smoking cigarettes? ❑ Yes ❑ No

If no, how old were you when you quit smoking? ______

How many packs per day did you (do you) average? ______

Do you smoke cigars? ❑ Yes ❑ No

If yes, how long long have you been smoking cigars? ______

Do you smoke a pipe? ❑ Yes ❑ No

If yes, how long long have you been smoking a pipe? ______

## Habits

Do you ever drink alcoholic beverages? ❑ Yes ❑ No

If yes, number of drinks per day ______

Have you ever used recreational drugs? ❑ Yes ❑ No

If yes, what drugs? ______

## Use of Medications

Please list all current ORAL and INHALED medications prescribed by your doctor and any nonprescription medicine(s) you are taking:

Medication: ______

Strength/Times Taken per Day ______

❑ Regular Use ❑ Taken Only as Needed

Medication: ______

Strength/Times Taken per Day ______

❑ Regular Use ❑ Taken Only as Needed

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## Use of Medications (continued)

**Medication:**
**Strength/Times Taken per Day** ______
❑ **Regular Use** ❑ **Taken Only as Needed**

**Medication:** ______
**Strength/Times Taken per Day** ______
❑ **Regular Use** ❑ **Taken Only as Needed**

**Medication:** ______
**Strength/Times Taken per Day** ______
❑ **Regular Use** ❑ **Taken Only as Needed**

**Medication:** ______
**Strength/Times Taken per Day** ______
❑ **Regular Use** ❑ **Taken Only as Needed**

**Medication:** ______
**Strength/Times Taken per Day** ______
❑ **Regular Use** ❑ **Taken Only as Needed**

**Medication:** ______
**Strength/Times Taken per Day** ______
❑ **Regular Use** ❑ **Taken Only as Needed**

**Medication:** ______
**Strength/Times Taken per Day** ______
❑ **Regular Use** ❑ **Taken Only as Needed**

## Use of Corticosteroid (Steroid) Medications

**Have you been on oral steroid medications (e.g., prednisone) in the past?** ❑ Yes ❑ No

**If yes, do you use oral steroids on a continuous or near-continuous basis?** ❑ Yes ❑ No

**How many months or years have you used steroids this way?** ______

**If you usually require oral steroids for control of your asthma, what is the approximate daily dose in milligrams (mg) needed?**______**mg**

**If you require intermittent doses of oral steroids, please list the number of courses used this year:**

______

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## Urgent Treatment

**How often do you use your rescue/quick-relief medicine for an asthma attack?** ______________

**Does it help?** ❑ Yes ❑ No

**How often in the last year have you been to your physician's office for unscheduled visits because of asthma?** ______________

**How often in the last year have you been to the Emergency Room for treatment of asthma?** ______________

**List all hospitalizations for asthma in the past 2 years:**

| DATE(S) OF HOSPITALIZATION | NAME OF HOSPITAL |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

## Past Medical History

**Please check any of the following you have ever experienced:**

- ❑ Glaucoma
- ❑ Thyroid disease
- ❑ Migraine headache
- ❑ Epilepsy or other seizures
- ❑ Heart disease
- ❑ Hypertension
- ❑ Pneumonia
- ❑ Tuberculosis
- ❑ Cancer
- ❑ Hiatal hernia
- ❑ Ulcers
- ❑ Inflammatory bowel disease
- ❑ Hepatitis
- ❑ Prostate disease
- ❑ Kidney stones
- ❑ Diabetes
- ❑ Stroke
- ❑ Positive tuberculin skin test
- ❑ Elevated cholesterol
- ❑ Osteoporosis
- ❑ Any severe infections
- ❑ AIDS or HIV+

**Please list all hospitalizations <u>other than f or asthma</u>:**

| DATE | DIAGNOSIS OR REASON FOR HOSPITALIZATION |
|---|---|
| | |
| | |
| | |
| | |

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## Surgical History

**Please list all surgical procedures and the date they were done:**

| Procedure | Date |
|---|---|
| | |
| | |
| | |
| | |
| | |

## Previous Tests Done

**List any previous testing you have had. Please give approximate dates and results.**

| | APPROXIMATE DATE | RESULTS |
|---|---|---|
| ❑ Chest x-ray | | |
| ❑ Sinus CT or x-ray | | |
| ❑ Bronchoscopy | | |
| ❑ Pulmonary function tests | | |
| ❑ Rhinoscopy | | |
| ❑ Sweat chloride | | |
| ❑ pH probe | | |
| ❑ Barium swallow | | |
| ❑ Immunoglobulin studies | | |
| ❑ Methacholine challenge | | |

## Family History

**Has anyone in your family (parents, siblings, aunts, uncles, grandparents) had: (check all that apply)**

❑ Heart disease ❑ Emphysema ❑ Hypertension ❑ Cystic fibrosis ❑ Diabetes

❑ Allergies ❑ Cancer ❑ Asthma ❑ Arthritis

**Date of most recent influenza vaccine (flu shot)** ____________________

**Date of pneumococcal vaccine** ____________________

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## Review of Symptoms

**Please circle any of the following symptoms which you are currently experiencing, or which have caused you *serious* problems in the past.**

**General:** Fever, weight loss, weight gain, night sweats, severe itching, loss of appetite, fatigue, cold intolerance, heat intolerance.

**Eye/Ear/Nose & Throat:** Loss of vision, blurry vision, cataracts, glaucoma, loss of hearing, itching in ear, ringing in the ears, loss of balance, loss of sense of smell, loss of sense of taste, excessive tearing, dry eyes, itchy eyes, conjunctivitis, ear infections, dry mouth, postnasal drainage.

**Lymph Glands:** Glandular swelling, glandular tenderness.

**Heart:** Chest pain, palpitations, swelling of ankles, inability to lie flat in bed.

**Intestinal Tract:** Nausea, vomiting, heartburn, indigestion, trouble swallowing liquids or food, abdominal pain, constipation, diarrhea, excessive gas, food intolerances, gallstones, acid or sour taste in mouth, blood in stool.

**Reproductive:** Irregular periods, skipped periods, unusual vaginal bleeding, menopause, infertility, miscarriages, impotence, unplanned pregnancy, planned pregnancy.

**Urinary:** Kidney stones, inability to urinate, prostate problems, kidney infections.

**Rheumatologic & Orthopedic:** Early morning joint stiffness, joint swelling, joint pain, gout, low back pain, osteoporosis, fractured bones.

**Skin:** Skin rash, hives, eczema, skin tumors or growths, excessive hair loss.

**Neurologic:** Fainting spells, severe headaches, epilepsy (seizures), difficulty with memory, inability to concentrate.

**Please elaborate on *any* symptoms which are particularly bothersome to you:** ______________________

______________________________________________

______________________________________________

## Dietary History

**Present Height:** ____________ **Present Weight:** ____________ **Usual Weight:** ____________

**Do you follow any special diet at home?** ❑ Yes ❑ No

**If yes, please explain:** ______________________________

**Do you avoid any major food groups, such as milk products, meats, fruits, vegetables, grains or wheat?** ❑ Yes ❑ No

**If yes, please explain:** ______________________________

**Do you have any food allergies?** ❑ Yes ❑ No

**If yes, please describe:** ______________________________

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## Occupational or School History

**Are you currently employed?** ❑ Yes ❑ No

**What is your current occupation?** ______________________

**How long have you worked in this occupation?** ______________________

**How many hours per week do you work?** ______________________

**Do you believe that your current or previous occupation has any bearing on your illness?** ❑ Yes ❑ No

**If yes, please explain:** ______________________

**Are you unemployed (or on medical leave of absence) due to your medical illness?** ❑ Yes ❑ No

**If yes, please explain:** ______________________

**Do you have any pending or planned legal action against your current or former employer which pertains to your medical illness?** ❑ Yes ❑ No

**Have you ever worked in a factory, textile mill, grain mill, shipyard or mine or on a farm?** ❑ Yes ❑ No

**If yes, please explain:** ______________________

**Have you had any job with high exposure to fumes, chemicals, dust or other noxious substances?** ❑ Yes ❑ No

**If yes, please explain:** ______________________

**How much work or school have you missed due to your breathing difficulty within the past year?** ______________________

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## Physical Activity

**What kind of exercise(s) do you perform regularly?** ______________________

______________________

**How often do you exercise?** ______________________

**Has your doctor placed limits on your exercise?** ❑ Yes ❑ No

**If yes, please explain:** ______________________

______________________

**Have you had an EKG, treadmill test, echocardiogram or cardiac catheterization?** ❑ Yes ❑ No

**If yes, please give name of test, date and the results of the test:** ______________________

______________________

______________________

**What (if any) hobbies or leisure activities do you engage in?** ______________________

______________________

______________________

______________________

## Educational History

**Child -** Current grade in school: ______________________

**Adult/Parent/Guardian -** Highest level of education: ______________________

Name:
ID Number:

**Questionnaire for Parent or Guardian (patient's early childhood history)**

**Child's birth weight** ______________________

**Was baby full term?** ❑ Yes ❑ No

**How was baby born?** ❑ Vaginal ❑ C-Section

**Did mother smoke during pregnancy?** ❑ Yes ❑ No

**Was child breast fed?** ❑ Yes ❑ No

**Any problems with food or formula during infancy?** ❑ Yes ❑ No

**If yes, please explain:** ______________________________________________

______________________________________________

______________________________________________

**Any allergies during infancy?** ❑ Yes ❑ No

**Did child ever have chronic ear infections?** ❑ Yes ❑ No

**Did child ever have chronic throat infections?** ❑ Yes ❑ No

**Did child ever have recurrent or spasmodic croup (wheezy bronchitis)?** ❑ Yes ❑ No

**Did child ever have respiratory syncytial virus (RSV) infection?** ❑ Yes ❑ No

**Was child ever in pediatric intensive care unit?** ❑ Yes ❑ No

**Has child ever been on a ventilator or have his/her airways ever been incubated?** ❑ Yes ❑ No