

## New Patient History

Patient's Name: \_\_\_\_\_ Age: \_\_\_\_\_  
*Last* *First* *Middle*

Primary Care or Referring Physician: \_\_\_\_\_

*Name*

*Address*

Please circle Yes or No

Symptoms:

Cough?	Yes/No
Wheeze?	Yes/No
Tight Chest?	Yes/No
Fatigue?	Yes/No
Shortness Of Breath?	Yes/No

Eye Symptoms:

Itching?	Yes/No
Watering?	Yes/No
Redness?	Yes/No
Puffiness?	Yes/No

Nasal Symptoms:

Nasal Drainage?	Yes/No
Sneezing?	Yes/No
Stuffy Nose?	Yes/No
Mouth Breathing?	Yes/No
Itch Of The Roof Of Your Mouth?	Yes/No
Snoring?	Yes/No
Sinus Headache?	Yes/No

Ear Symptoms:

Itching?	Yes/No
Infections?	Yes/No

Skin Symptoms:

Hives?	Yes/No
Rashes?	Yes/No
Eczema?	Yes/No

Have you had sinus infections? Yes/No  
*If yes, how often?* \_\_\_\_\_

Do symptoms awaken you at night? Yes/No  
*If yes, which symptoms and how often?* \_\_\_\_\_

Are you limited in your daily activities? Yes/No

Do you miss days of work/school because of your illness? Yes/No  
*If yes, how many in the last year?* \_\_\_\_\_

Have you gone to the emergency room because of asthma /allergy episodes? Yes/No

**Allergy/Asthma Triggers**

Which of the following trigger your symptoms?

- Certain times of the year? Yes/No *If yes, Which Times?* \_\_\_\_\_
- Open Windows? Yes/No
- Animals? Yes/No *If yes, Which Ones?* \_\_\_\_\_
- Cutting Grass? Yes/No
- Foods? Yes/No *If yes, Which Ones?* \_\_\_\_\_
- House Dust/Vacuuming? Yes/No
- Damp, Musty Areas? Yes/No
- Cold Air? Yes/No
- Exercise? Yes/No
- Irritants (Perfumes, Aerosol Sprays, Etc.)? Yes/No

**Medical/Allergy Testing**

Have you ever had?

Chest X-Ray: Yes/No  
*If yes, date of most recent X-Ray:* \_\_\_\_\_ *Where was test done?* \_\_\_\_\_

Results: \_\_\_\_\_

Sinus X-Ray or CAT Scan of sinuses? Yes/No  
*If yes, date?* \_\_\_\_\_ *Where was test done?* \_\_\_\_\_

Results: \_\_\_\_\_

Allergy Testing? Yes/No  
*If yes, date of most recent test:* \_\_\_\_\_ *Where was test done?* \_\_\_\_\_

Results: \_\_\_\_\_

Have you ever taken allergy shots? Yes/No  
*If yes, for how long?* \_\_\_\_\_ *When?* \_\_\_\_\_

Pulmonary Function Testing? Yes/No  
*If yes, date of most recent test:* \_\_\_\_\_ *Where was test done?* \_\_\_\_\_

Results: \_\_\_\_\_

**List your current allergy/asthma medications, including over-the-counter medications:**

<i>Medication</i>	<i>Dose</i>	<i>How Often</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**List your other medications, including over-the-counter medications:**

<i>Medication</i>	<i>Dose</i>	<i>How Often</i>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have ever taken prednisone, cortisone, or other steroids (by mouth)? Yes/No

Are you allergic or sensitive to any medications? Yes/No

If yes, which ones? \_\_\_\_\_

**Family History**

Do other family members have asthma, sinus problems, or frequent infections? Yes/No

If yes, who? \_\_\_\_\_

**Pregnancy**

Are you currently pregnant? Yes/No *Not applicable (if male, postmenopausal, or child)*

Are you planning a pregnancy? Yes/No

**Smoking**

Do you currently smoke? Yes/No

Have you smoked in the past? Yes/No

If yes, for how many years? \_\_\_\_\_ How much a day? \_\_\_\_\_ When did you quit? \_\_\_\_\_

Does anyone in your home smoke? Yes/No

Do you drink alcoholic beverages? Yes/No

If yes, how many drinks per day? \_\_\_\_\_

**Type of Home**

\_\_\_\_\_ Single-family dwelling      Age of home: \_\_\_\_\_

\_\_\_\_\_ Apartment

\_\_\_\_\_ Condo

\_\_\_\_\_ Mobile Home

Is there a basement? Yes/No

If yes, is it? \_\_\_ Always dry \_\_\_ Rarely leaky \_\_\_ Frequently leaky

Does your basement smell damp or musty? Yes/No

If no basement, is there a? \_\_\_ Concrete slab \_\_\_ Crawlspace

### Heat/AC

Air Conditioning? Yes/No  Window Unit  Central  
Heat? Yes/No  Gas  Electrical  Radiant  Wood  
Humidifier on furnace? Yes/No  
Do you use a fireplace or wood-burning stove? Yes/No  
If yes, how often: \_\_\_\_\_  
Do you open windows in mild weather? Yes/No  
Do you have an attic fan? Yes/No

### Bedroom

Location of bedroom:  Basement  Ground floor  Second floor or above  
Floor cover in bedroom:  Carpet  Tile  Hardwood  Linoleum  
 Other \_\_\_\_\_  
If carpet, how old? \_\_\_\_\_/\_\_\_\_\_ months/years Composition, if known: \_\_\_\_\_  
Stuffed animals in bedroom? Yes/No  
If yes, how many: \_\_\_\_\_

### Mattress

Waterbed  Conventional/Fiber-Filled  
Fiber content: \_\_\_\_\_ Age: \_\_\_\_\_ / \_\_\_\_\_ months/years

### Pillows

Fiber content?  Polyester-filled  Feather/down  Foam rubber  
Age of pillow? \_\_\_\_\_ / \_\_\_\_\_ months/years  
Do you have a down comforter? Yes/No

### Animals/Pets

Do you have animals/pets? Yes/No  
If yes, kind(s) indoor: \_\_\_\_\_  
If yes, kind(s) outdoor: \_\_\_\_\_  
If yes, how long have you had the animal(s)? \_\_\_\_\_

### House Plants

Do you have houseplants? Yes/No  
If yes, how many: \_\_\_\_\_

**Medical History**

*Please circle Yes or No:*

*Have you ever had?*

Bronchitis?	Yes/No	Blood disease?	Yes/No
Pneumonia?	Yes/No	Anemia?	Yes/No
Emphysema?	Yes/No	Osteoporosis?	Yes/No
Exposure to tuberculosis?	Yes/No	Bone fractures?	Yes/No
Positive TB skin test?	Yes/No	Stomach problems?	Yes/No
Other lung disease?	Yes/No	Ulcers?	Yes/No
Heart Problems?	Yes/No	Hernias?	Yes/No
Heart Attack?	Yes/No	Eye problems?	Yes/No
High blood pressure?	Yes/No	Cataracts?	Yes/No
High Cholesterol?	Yes/No	Glaucoma?	Yes/No
Diabetes?	Yes/No	Seizures?	Yes/No
Kidney disease?	Yes/No	Have you ever needed oxygen?	Yes/No
Liver disease?	Yes/No	Have you ever stopped breathing?	Yes/No
Cancer?	Yes/No		

**Have you ever been hospitalized:** Yes/No

*If yes, give reason and dates:*

*Reason for Hospitalization:*

*Dates:*

_____	_____
_____	_____
_____	_____
_____	_____

**Have you ever had surgery?** Yes/No

*If yes, give reasons/procedures, dates:*

*Reason:*

*Procedure/s:*

*Dates:*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Pediatric Patients Only**

Length of pregnancy? \_\_\_\_\_ months

Were there problems during pregnancy, delivery, or newborn period? Yes/No

If yes, please explain: \_\_\_\_\_

Birth weight: \_\_\_\_\_ lbs. \_\_\_\_\_ oz.

Has your child had chicken pox? Yes/No

Has your child had RSV? Yes/No

Are your child's immunizations up to date? Yes/No

Dr. Onder and Allergy and Asthma Consultants, P.C. conduct clinical research studies on new allergy and asthma medications. Would you be interested in you or your child participating in studies of new medications?

\_\_\_ Yes      \_\_\_ No      \_\_\_ Maybe

*Please do not write below this line*

ROS: \_\_\_\_\_

P.E. \_\_\_\_\_

HT. \_\_\_\_\_ WT. \_\_\_\_\_ B.P. \_\_\_\_\_

Appearance: WNWD \_\_\_\_\_ OTHER: \_\_\_\_\_

Eyes: \_\_\_\_\_

L.N. \_\_\_\_\_ Ears: \_\_\_\_\_ Nares: \_\_\_\_\_

Lungs: \_\_\_\_\_

C.V.: \_\_\_\_\_ Skin: \_\_\_\_\_

A/P: \_\_\_\_\_