Name:_____ Date of Birth:_____ MRN: _____ Appointment Date:_____

Past Medical and Allergic History
Hospitalization:
Emergency Room Visits:
Medical:
Surgery:
Food Reactions:
Drug Reactions:
Latex:
Insect Stings:
Immunizations:

HOME: Answer the following questions regarding the house you now live in.

Do you live in a (circle) House Condo Apartment Other: _____

Do you live in the (circle) City Town Rural

How old is your home? _____ **How long have you lived there?** _____

Type of heating: Forced Air Water Oil Electric Wood burning

Type of air conditioning: Central Air Window Unit Swamp Cooler None

Type of air filter: HEPA None

Separate air cleaner attached to furnace? None Electrostatic UV light HEPA

Type of humidifier: _____ **Attached to furnace?** Yes No

Do you have a dehumidifier in your home? Yes No

Basement: Damp Dry Finished Unfinished None

Any recent water damage? Yes No

Are there houseplants? Yes No **How many plants?**_____ **Location?**_____

Do you have any Cockroaches Mice Miller Moths Other insects:_____

Are there any smokers within the household? Yes No **Do they smoke in the home?** Yes No

Pets in the home? Yes No **What type of pet and how many?**_____

What percentage of the time do they spend outside: _____% inside: _____%

Do they sleep in the patient's bedroom or on the bed? Yes No

How long has each pet been in the family? _____

PATIENT'S BEDROOM: **How often is it cleaned?** _____ **By whom?** _____

Types of: **Floors Coverings:** _____ **Furniture:** _____ **Comforter:** _____

Type of pillows: Feather Foam Poly-fil Other _____

Type of mattress: _____ **Age of mattress:**_____ **Allergy covers?** Yes No

HOBBIES/WORK: **Hobbies/Recreational Activities**: _____

Age 18 years and older: **Occupation:** _____ How Long: _____

Past Occupation: _____ How Long: _____

Age under 18 years: **Grade in school:** _____

Do your symptoms at work/school? (circle) **Improve** **Worsen**

SOCIAL HISTORY: Please answer the following questions if you have used or are currently using tobacco products.

Current or Past Smoker (please circle)

How long have /had you used tobacco products? _____

How much tobacco did/do you use per day? _____

Did/do you use (circle all that apply) Cigarettes Cigars Pipe

Past smokers, how long ago did you quit? _____

Do you drink alcohol? Yes No How much? _____

Do you use illegal or recreational drugs? Yes No What? _____ How much?_____

FAMILY HISTORY

	CURRENT AGE	AGE OF DEATH (if applicable)	HEALTH PROBLEMS	CAUSE OF DEATH (if applicable)
PARENT:				
PARENT:				
SIBILING:				
SIBILING:				
CHILD:				
CHILD:				
CHILD:				

PLEASE INDICATE IF THERE IS ANY HISTORY OF THE FOLLOWING FOR YOURSELF OR A FAMILY MEMBER:

History	Yes	No	Family Member with History	History	Yes	No	Family Member with History
Hay Fever				Tuberculosis			
Asthma				Anemia			
Hives				Hypertension			
Atopic Dermatitis (Eczema)				Stroke			
				Heart Disease			
Chronic Sinus Problems				Arthritis			
Nasal Polyps				Diabetes			
Bee/Wasp Allergy				Epilepsy			
Adverse Drug Reaction				Headache			
Food Allergy				Kidney Disease			
Cystic Fibrosis				Cancer			
Chronic Bronchitis				AIDS/HIV			

REVIEW OF SYSTEMS

Are you currently experiencing any problems with (check box and circle complaint):

Y☐ N☐ weight change – fatigue – fever - headaches
Y☐ N☐ rashes – lumps – itching - changes in skin, hair, nails
Y☐ N☐ double or blurred vision – glaucoma – cataracts - eye discharge
Y☐ N☐ earache - hearing loss - ringing in the ears
Y☐ N☐ nose bleeds - stuffiness - sinus trouble - sinus infection
Y☐ N☐ bleeding gums - gingivitis - tooth decay - hoarseness
Y☐ N☐ cough - shortness of breath - wheezing - asthma - phlegm
Y☐ N☐ high blood pressure, heart trouble, chest pain, murmurs, rhythm disturbance, stroke
Date of last: Chest x-ray _____ EKG _____ TB tine _____
Y☐ N☐ trouble swallowing – stomach problems - vomiting - heartburn - loss of appetite
Y☐ N☐ constipation - diarrhea - bloody or dark stools - hemorrhoids - hepatitis - liver or gallbladder disease
Y☐ N☐ burning or blood in urine - urinary frequency - incontinence - infections - stones
Y☐ N☐ varicose veins - blood clots - anemia - easy bruising/bleeding
Y☐ N☐ depression - mental illness
Y☐ N☐ **FEMALES:** veneral disease - PMS - menopause - breast lumps/discharge
Date of last period: _____ Mammogram _____
Y☐ N☐ **MALES:** penile discharge/lesion - venereal disease - testicular pain - hernia - breast lumps/discharge