ALLERGY-ASTHMA CLINIC OF KENOSHA, SC ALLERGY-ASTHMA CLINIC OF RACINE

Name Date of Birth / / Date: / /
The information given is confidential and will not be released without your written permission.

History of Present Illness

Chief Complaint/s Please list the main **reason/s** for your visit today, in the chronological order these appeared.

Problem When did you first notice it (days, weeks, months, years)?
1.
2.
3.

How **severe** is your problem/s? Mild Moderate Very Severe
Does anything make the problem worse? Indoors/outdoors At-work or Home
Near Pets Dust Weather-changes Smoke other
Does anything that makes your problem better?
Medications Air-conditioning other

Do the symptoms interference with your sleep, work, school or leisure activities?
Are your symptoms present all the time or come and go?
Are there any seasonal changes in your symptoms?
Have you tried any medications prescribed or over-the-counter?
Are your symptoms getting better, worse or the same since starting?
Anything else you think is important?

Please fill in below what applies to your problem. Answer yes or no, or circle choice.

NOSE: itching-------congestion--------runny----------watery discharge----------excessive sneezing--
post nasal drip---------- nasal polyp----------loss of smell---------- fever----------'sinus infections'---------- 'colds'-----other----------

EYES: itching---------watering----------redness----------sensitive to light----------swelling of lids-
Any discharge---------Color of discharge--------- Do you wear contacts?---------other----------

--EARS: Plugged---------- Ache----------Discharge----------Infection/s----------Tubes put in----

Hearing loss---------other----------
HEADACHES: How often----------Which part of the head----------
Any accompanying symptoms----------Treatment----------

ASTHMA: Do you know if you have asthma?
How long you had it?
How often do you have wheezing?
How does it start e.g. with colds or exercise etc?
Is your wheezing worse during the day or during the night?
Do you know what causes your wheezing?
How severe is the wheezing usually?
Do you have bouts of coughing, chest tightness or difficulty breathing?
What do you do to relieve it?
List medications that you are taking for asthma?

Do these help?
Have you had steroids for wheezing?

Is your asthma worse, better, or the same since it started?
Give months of the year your wheezing is worse or is it yearround?.
How often do you get severe wheezing?
Have you been to the emergency room or hospitalized for asthma?
If so when and where?

Past History

Have you ever consulted an allergist before?
If yes, give name and address
Give diagnosis and treatment

Allergic to Latex (rubber)? No Yes Describe reaction

RESPIRATORY INFECTIONS: Do you get frequent 'colds', sore throat, sinus infections, bronchitis or pneumonia?

SKIN: Eczema as a child or now or rash?

Any reaction from insect stings or bites? No Yes, Describe
FOODS: Any foods you cannot eat and why?

Describe any feeding problems as a baby?
List Major **Illnesses**(High blood pressure, diabetes, thyroid problem, heart disease, depression seizures, GE acid reflux etc.) **surgery**, or **Injuries** in the past

Allergy to Medications? No Yes Please list medication/s and describe the reaction.
1.
2.
3.
4.

Did you or do you miss school or work because of health reasons?
Did you have your childhood immunizations?
Did you have influenza or pneumonia immunizations?
Any reactions from your immunizations?
Did you have TB skin test? Was it positive or negative?
When was your last complete physical examination?
Result
When was your last blood, urine test, chest or sinus X-ray?

Result:

Family History

Give any disease (blood pressure, diabetes etc.), particularly allergies and asthma in the family.
Father
Mother
Brother/
Sister/
Son/s
Daughter/s
In the nearest blood relatives

GENERAL INFORMATION: Are you a *Never Smoker*
Current Smoker: For years Smokeless Ounce/day Cigars/ Day
Cigarettes Pack/s Per Day
Former Smoker, Date Quit?
Date of last quit attempt, if applicable
If Former smoker for how long and what did you smoke, before quitting?
Does someone else smoke in your house or at work?
Do you drink alcohol? N Y If yes, what (beer, wine, liquor), how much
and how often Daily, Weekly, Occassionally?
Caffeine? Coffee N Y if yes, regular, decaffeinated and how many cups a day?
Soda with Caffeine how much a day
Chocolate

Do you use or have used any illegal drugs? List if any

List **all medications** that you are taking now whether prescribed, over-the-counter. Also,

vitamins, tonics, herbs and teas, etc.

ENVIRONMENTAL HISTORY: Living in house or apartment City or county
Type of heating system: air conditioning Humidifier
Basement: dry damp heated dehumidified musty
House plants: how many kept where
Bedroom: Type of mattress Spring foam
Pillow stuffing: Feathers foam-rubber kapok dacron/polyester
Pillow cover: Cotton synthetic combination other
Type of bedspread: comforter Type of curtains or drapes:
Floor covering:
Other things kept in bedroom

Pets: inside/outside sleeps in bedroom
Symptoms worse near pets?
Describe the environment at work.
Any relation of symptoms to work?
Any hobbies?
Any relation of symptoms to hobbies?

Do your symptoms get worse when you are near: old leaves in the barn eat cheese or mushrooms drink beer lakeside mowing lawn near freshly mowed lawn cleaning house, attic, or basement making beds, heat first turned on, sitting on old furniture, taking aspirin at school, cosmetics, perfumes, hair spray, wave set House cleaners lint, plants, insecticides, insect sprays, newspaper dyes, wool, soap, detergents, other/s

Systemic Review:
Do you have now or in the past had any problem related to the following systems?
Please circle what you have.

Constitutional Symptoms			Neurological		
Fever	N	Y	Tremors	N	Y
Chills	N	Y	Dizzy spells	N	Y
Headache	N	Y	Numbness/tingling	N	Y
Weight loss	N	Y	Convulsions/seizures	N	Y
Gastrointestinal			Musculoskeletal		
Abdominal Pain	N	Y	Joint pains	N	Y
Nausea/Vomiting	N	Y	Neck pain	N	Y
Indigestion/heartburn	N	Y	Back pain	N	Y
Constipation/diarrhea	N	Y	Muscle weakness	N	Y
Cardiovascular			Hematological/lymphatic		
Chest pain	N	Y	Swollen glands	N	Y
High blood pressure	N	Y	Blood clotting	N	Y
Circulation problem	N	Y	Other	N	Y
Shortness of breath	N	Y			

Endocrine

Excessive thirst	N	Y
Feeling too hot/cold	N	Y
Tired/ sluggish	N	Y

Genitourinary

Urine retention	N	Y
Painful urination	N	Y
Urinary frequency	N	Y
Ladies Are your periods regular	N	Y
Are you **pregnant?**	N	Y Not sure

Psychological

Are you generally satisfied with you life?	N	Y
Do you feel severely depressed?	N	Y
Do feel anxious or nervous most of the time?	N	Y
Tendency to worry lot or panic attacks	N	Y

Please give any other information you think we should have.

Any questions or concerns you would like to discuss with us? Please make a note.

Fill the rest of the form only if you have hives.

HIVES: How long you had the hives?----------How extensive? ----------
How severe----------size---------- how often---------- how extensive--
itching---------- other----------
Swelling of lips/tongue/ throat----------any difficulty breathing or swallowing
Taking any medication, prescribed or over the counter?----------
-
List medications----------
-
List vitamins/tonics, herbs etc.----------
-
Aspirin/Antacids----------
--
Birth control pills/Hormones----------
-
Creams/Suppositories/Intrauterine devices, douches etc.----------
-
Contraceptives?----------
-
Do you use any rubber (latex) products?----------
--
Took any antibiotics recently?----------
--
Recent tests for gall bladder, kidney etc.----------
--
Stomach or bowel trouble----------
--
Any known infection-teeth/sinus/urine etc.----------
--

Recent respiratory infection----------
-
Travel or lived abroad or in the south----------
-
Appetite----------Weight steady----------
--
Emotions affect hives----------
--
Any body in the family with hives----------
--
Hives from cold, heat, vibration----------
--
Hives on exercise----------
--
Hives from contact with plants/animals etc.----------
--
Hives from food dyes/candy/drinks etc.----------
-
Use artificial sweetener----------
--
Other information----------
-