

Complete the following information. Please put an **X** in each box that relates to your problems.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Date of First Visit: \_\_\_\_\_

(Please Print)

Were you referred by a physician or other provider?  no  yes If yes, who \_\_\_\_\_

Briefly state what symptoms are bringing you here: \_\_\_\_\_

**Upper Respiratory Tract (Nose, Sinus, Ear, and Eye) Problems**

**Note: If No Upper Respiratory Tract problems, Check Here  And Go To Page 2 – Lower Respiratory Tract.**

When did these symptoms first begin? \_\_\_\_\_

- sneezing  itching nose
- nasal congestion  stuffiness
  - if so:  right side  left side  both sides
- runny nose; what color is the mucus? \_\_\_\_\_
- post-nasal drip  drainage cough  sore throat
- decreased or absent sense of smell
- nose bleeds  snoring  bad breath
- nasal polyps; if so:  past  present
- frequent colds; if so, how many per year? 1-5  5-10
- headaches/sinus pain; if so, location: \_\_\_\_\_
  - how often per month: 1-5  5-10  more than 10
- recurrent ear infections  ear plugging/popping/fullness
- hearing loss; if so, was hearing tested? yes  no

- septum deviated  septum perforated
- previous nose injury; if so, was nose broken?  yes  no
- previous nasal or sinus surgery; if so, when? \_\_\_\_\_
- recurrent or chronic sinus infections; if so, how many per year?
  - 0-4  over 4
- sinus x-rays or sinus CT scan done
  - if so, when? \_\_\_\_\_
  - result  normal  abnormal
- ENT evaluation; if so, when? \_\_\_\_\_
  - name of doctor: \_\_\_\_\_

- Eyes:  itch  red  watering  swollen lids
- fatigue/tired  poor concentration
- other: \_\_\_\_\_

**Symptoms Caused Or Aggravated By:**

- cold air  weather change
- temperature change  damp/humid weather
- odors/scents/fragrance  tobacco smoke
- your workplace or school  aspirin/related medications
- dusting/vacuuming  musty odors/mold
- yard work  pollens  being outdoors
- animals, list: \_\_\_\_\_
- other: \_\_\_\_\_

- Year-round symptoms?  yes  no
- Season(s) in which symptoms are **worst**: (“X” all that apply)
- spring  summer  fall  winter
- Frequency of upper respiratory tract symptoms:
- daily \_\_\_\_\_ times per week \_\_\_\_\_ times per month
- other: \_\_\_\_\_
- Symptoms interfere with:  sleep  exercise/activity
- school (missed days)  work (missed days)
- how often do symptoms interfere? \_\_\_\_\_
- Symptoms are:  improving  worsening  unchanged

List medications tried for **upper respiratory** symptoms (include prescription and over-the-counter oral medications and nasal sprays):

Name of Medication	Past	Current	Did it work?	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name \_\_\_\_\_

## Lower Respiratory Tract (Chest, Lung) Problems

**Note: If No LOWER Respiratory Tract Problems, Check Here  And Go To Page 3.**

When did chest symptoms first begin? \_\_\_\_\_

- chronic or recurrent cough; if so, cough is:
  - dry     loose     coughing spells
  - if loose, is mucus coughed up?     yes     no
    - if yes, mucus color is: \_\_\_\_\_
  - occur at night during sleep:     yes     no
  - coughed up blood:     yes     no
- wheezing; when breathing     out     in
- chest tightness or pressure     throat tightness
- shortness of breath     difficulty taking a full breath
- awakening at night with chest symptoms     yes     no
- asthma diagnosed by a physician?    age: \_\_\_\_\_
- emergency room visit(s) for asthma; if so, how many times? \_\_\_\_\_
  - date of last ER visit: \_\_\_\_\_
- hospitalized for asthma; if so, number of times? \_\_\_\_\_
  - date of last hospitalization: \_\_\_\_\_
- intensive care unit for asthma; when: \_\_\_\_\_
  - if so, were you on a ventilator/respirator?     yes     no

- oral steroids (Prednisone, Medrol, Prelone, etc.) taken for asthma
  - if so, number of times taken per year:
    - 1     2 - 5     greater than 5
  - date of last use: \_\_\_\_\_
- history of recurrent bronchitis
- history of recurrent pneumonia
- history of recurrent croup
- previous chest x-ray or chest CT scan; if so, when? \_\_\_\_\_
  - result:     normal     abnormal
- peak flow meter used; if so, best reading: \_\_\_\_\_
- pulmonary function (lung) test:     yes     no
- pulmonary (lung specialist) evaluation; when: \_\_\_\_\_
  - specialist's name: \_\_\_\_\_
- other symptoms (list): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

### Symptoms Caused Or Aggravated By:

- colds/upper respiratory infections     sinus infections
- exertion/exercise; type: \_\_\_\_\_
- cold air     weather change     temperature change
- odors/scents/fragrance     tobacco smoke
- eating/drinking     heartburn/acid reflux
- emotional stress/anger     laughing/crying
- your workplace or school
- aspirin/related medications
- dusting/vacuuuming     musty odors/mold
- yard work     pollens     being outdoors
- animals, list: \_\_\_\_\_
- other: \_\_\_\_\_

- Year-round symptoms?     yes     no
- Season(s) in which symptoms are **worst**: ("X" all that apply)
  - spring     summer     fall     winter
- Frequency of lower respiratory tract symptoms:
  - daily    \_\_\_ times per week    \_\_\_ times per month
  - other: \_\_\_\_\_
- Symptoms interfere with:     sleep     exercise/activity
  - school (missed days)     work (missed days)
  - how often do symptoms interfere? \_\_\_\_\_
- Symptoms are:     improving     worsening     unchanged

List medications tried for **lower respiratory** symptoms (include prescription and over-the-counter oral, inhaled, and injected medications):

Name of Medication	Past	Current	Did it work?	
<input type="checkbox"/> Albuterol <input type="checkbox"/> inhaler <input type="checkbox"/> nebulizer    How often used? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no

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### Skin Problems

**Note: If No Skin Problems, Check Here  And Go To Page 4.**

When did skin symptoms first begin? \_\_\_\_\_ Eczema started when: \_\_\_\_\_

- itching
- welts/hives When did welts/hives start? \_\_\_\_\_
- excessively dry, scaly skin
- skin swelling  face  lips  tongue /throat  hands/feet
- irritated red patches
- weepy, oozing rash
- recurrent skin infections
- other symptoms (list): \_\_\_\_\_

Location of rash: \_\_\_\_\_

Frequency of above symptoms:  daily \_\_\_\_\_ times per week \_\_\_\_\_ times per month  other: \_\_\_\_\_

Are skin symptoms present year-round?  yes  no

Season(s) in which above symptoms are worst:  spring  summer  fall  winter

Has a physician diagnosed your rash?  yes  no

- if yes, what was the diagnosis?  hives  eczema  contact dermatitis  other: \_\_\_\_\_

Have you seen a dermatologist for your skin problems?  yes  no

- if yes, name of doctor: \_\_\_\_\_ when seen: \_\_\_\_\_

List everything that causes or aggravates your skin symptoms:


List medications tried for above symptoms (include prescription and over-the-counter oral medications, creams, and ointments):

Name of Medication	Past	Current	Did it work?	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no

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Name: \_\_\_\_\_

**Previous Allergy Evaluation(s):**  no  yes Date(s): \_\_\_\_\_

Skin testing:  no  yes Blood testing for allergy:  no  yes

Results of previous allergy testing (bring records if available): \_\_\_\_\_

Were you allergic?  no  yes

• if allergic, was it to:  animals  dust/mites  pollen  mold  food

other (list): \_\_\_\_\_

Allergist: Name: \_\_\_\_\_ State: \_\_\_\_\_

Previous allergy injection(s):  no  yes

If yes, date(s) started: \_\_\_\_\_ date(s) stopped: \_\_\_\_\_

• were allergy injections effective?  no  yes  not sure

• adverse reactions to allergy injection(s)?  no  yes; if yes, list: \_\_\_\_\_

**Insect Sting Reactions:**  no  yes

If yes, insect(s) causing reaction: \_\_\_\_\_

• symptoms:  large swelling at site  hives  breathing problems  dizzy /lightheaded

other (list): \_\_\_\_\_

When did this occur? \_\_\_\_\_ Epinephrine /adrenlin device prescribed?  no  yes

**Drug Allergies / Intolerances:**  no  yes

Name Or Type Of Medication

Reaction(s) Noted

When Did  
Reaction Occur?  
Age or Date

Is The Medication  
Completely Avoided?

_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

**Food Allergies / Intolerances:**  no  yes

Food

Reaction(s) Noted

When Did  
Reaction Occur?  
Age or Date

Is The Food  
Completely Avoided?

_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes <input type="checkbox"/> no

**Latex Rubber Allergies / Intolerances:**  no  yes

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

\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

**Past Medical History:**

Flu vaccine:  no  yes; if yes, when? \_\_\_\_\_ Pneumonia vaccine:  no  yes; if yes, when? \_\_\_\_\_  
T.B. test:  no  yes; if yes, when? \_\_\_\_\_; result:  positive  negative  
Heart problems:  no  yes; if yes, describe: \_\_\_\_\_  
Blood pressure problems:  no  yes; if yes, treatment: \_\_\_\_\_  
Other medical problems: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Birth history (if patient is a child):  normal  premature \_\_\_\_\_

Hospitalization(s):  none \_\_\_\_\_

Surgery(s):  none \_\_\_\_\_

Serious injury(s):  none \_\_\_\_\_

**All Other Current Medications (Include Over-The-Counter And Supplements)**

Medication	Dosage	Frequency (how often)

**Family History:**

Do any close family members have the following? **Check the appropriate box below:** (even if mild or outgrown)

	Father	Mother	Brothers	Sisters	Children
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other diseases that run in the family:

Immune problems  yes  no      Cystic Fibrosis  yes  no      Emphysema  yes  no  
Family member: \_\_\_\_\_

**Social History:**

Have you ever smoked?  no  yes; if yes, for how many years: \_\_\_\_\_  
If yes, are you a current smoker?  yes  no; if no, when did you quit: \_\_\_\_\_  
• how much do/did you smoke? Number of packs per day  less than 1/2  1/2  1  2 or more  
Do you consume alcoholic beverages?  no  yes; if yes, how much: \_\_\_\_\_  
Use marijuana or other "recreational" drugs?  no  yes; if yes, how often: \_\_\_\_\_

Name: \_\_\_\_\_

### General

- Good general health
- Weight gain; past year: \_\_\_\_\_ lbs.
- Weight loss; \_\_\_\_\_ lbs.
  - dieting  yes  no
- Excessive tiredness
- Excessive thirst /drinking
- Recurrent fever
- Recurrent night sweats
- Pregnant  planning within year
- Cancer history
  - type: \_\_\_\_\_

### Eyes

- Dry eyes
- Wear contact lenses
- Cataracts
- Glaucoma

### Mouth /Throat

- Excess dryness of mouth
- Excessive throat mucus\*
- Throat clearing\*
- Hoarseness or voice problems\*
- Sensation of something stuck in throat\*

### Heart

- Palpitation or pounding of heart
- Irregular heart beat
- Angina /chest pain /tightness
- History of heart attack
- Thrombophlebitis /blood clots
- Swollen ankles /feet

### Gastrointestinal

- Difficulty swallowing\*
- Heartburn /acid indigestion /reflux
  - stomach acid coming up\*
  - frequency; \_\_\_\_\_
- History of ulcer
- Frequent spitting up or wet burps (infants)
- Hiatal hernia
- Recurrent vomiting
- Frequent diarrhea
- Bloody or black stools
- "Greasy" /bulky stools
- Liver disease: \_\_\_\_\_
- History of Hepatitis
  - Hepatitis Type:  A  B  C
  - if so, when diagnosed \_\_\_\_\_
- Other intestinal problems; \_\_\_\_\_
- Evaluation by GI specialist
  - when; \_\_\_\_\_
  - name: \_\_\_\_\_

### Genitourinary

- Kidney trouble
- Protein or sugar in urine
- Prostate problem
- Frequent urination

### Musculoskeletal

- Painful or stiff joints
- Swollen joints
- Rheumatoid Arthritis
- Osteoarthritis (age /injury related)
- Osteoporosis
- Scoliosis /spine curvature

### Endocrine

- Thyroid gland problems
- Adrenal gland problems
- Diabetes

### Neurologic

- Headache
  - migraine  other
  - how often; \_\_\_\_\_
- Hyperactivity /ADD /ADHD
- Dizzy spells
- Fainting spells
- Convulsions /epilepsy /seizures
- Head or neck injury
- Insomnia
- Depression
- Anxiety
- Ever see a psychiatrist /psychologist?
  - Currently see one

### Blood /Lymphatic

- Blood disorder: \_\_\_\_\_
- Anemia
- Bruise easily
- Swollen lymph nodes
  - if so, where? \_\_\_\_\_
- Previous blood transfusion
- Risk factors for AIDS
- Testing for HIV
  - if so, result:  positive  negative
- Other symptoms or medical problems (list)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name: \_\_\_\_\_

## Environmental History

How long has patient lived in Colorado? \_\_\_\_\_

What other states/countries has patient lived in? \_\_\_\_\_

### Instructions: Please fill out completely.

#### Primary Home (for patient living in two homes, see bottom of page 8)

Location:  city  suburb  rural  farm      Approximate elevation: \_\_\_\_\_

Type:  house  townhouse  condominium  apartment  mobile home  other: \_\_\_\_\_

Age of home: \_\_\_\_\_ Length of time in home: \_\_\_\_\_ (months, years).

Number of people, and who live in home: \_\_\_\_\_ List (patient, mother, son, etc.): \_\_\_\_\_

#### Construction

Basement:  none  finished  unfinished  walkout  earth  moisture problem

Crawl space:  none  yes  moisture problem

#### Heating and Cooling

Heat:  forced air furnace  hot water or radiant heat  electric baseboard  kerosene  propane  
 woodburning stove  woodburning fireplace  gas fireplace

Cooling system:  none  central air  window air conditioner  swamp cooler  attic fan

Central filter type:  none  fiberglass  HEPA  electrostatic

Frequency of filter change or cleaning: \_\_\_\_\_

Room air filter:  none  HEPA  electrostatic  ion generator  other: \_\_\_\_\_

Location of room air filter: \_\_\_\_\_

Air Ducts cleaned:  no  yes; if yes, when: \_\_\_\_\_

#### Mold and Moisture

Humidifier:  none  furnace  cold-mist  ultrasonic  steam      Frequency of cleaning: \_\_\_\_\_

Water leak(s):  none  past  current      If past or current leak(s), where? \_\_\_\_\_

musty odor  visible mold; location: \_\_\_\_\_

#### Cleaning

Frequency of dusting:  daily  2-3 times per week  1 time per week  every 2-4 weeks

Frequency of vacuuming:  daily  2-3 times per week  1 time per week  every 2-4 weeks

Type of vacuum:  upright  canister  water-filled  HEPA

Type of vacuum bag:  permanent  disposable

Name: \_\_\_\_\_

### Environmental History (continued)

#### Patient's Bedroom

Location:  basement  main floor  upper floor

Flooring:  wood  tile  linoleum  area rug  wall to wall carpet; if so:  shag  pile

Window Coverings:  none  curtains  drapes  shades  blinds

In warm seasons, sleep with windows:  open  closed

Beds (consider all beds in room):

Mattress:  innerspring  foam  waterbed  bunk  futon

Pillow:  feather (down)  foam  synthetic

Other bedding items:  feather (down comforter)  cotton  synthetic

Is mattress from another state?  no  yes; if yes, what state? \_\_\_\_\_

#### Pets

no  yes

	Number	How Long Owned?	Type/Breed	Outside	Inside	Allowed in Bedroom	Sleep in Bedroom
<input type="checkbox"/> Dog(s)	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cat(s)	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other(s)	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

#### Smokers (at your home)

No one  patient  mother  father  husband  wife  other: \_\_\_\_\_

#### Other Environments

	Number of days per week spent	Animals	Smokers
Daycare	_____	<input type="checkbox"/>	<input type="checkbox"/>
Relatives' Homes	_____	<input type="checkbox"/>	<input type="checkbox"/>
School/Work	_____	<input type="checkbox"/>	<input type="checkbox"/>
Vacation Home	_____	<input type="checkbox"/>	<input type="checkbox"/>
Friends that you visit	_____	<input type="checkbox"/>	<input type="checkbox"/>

#### Hobbies / Interests

Indoor: \_\_\_\_\_

Outdoor: \_\_\_\_\_

#### Occupation / School / Daycare

Type of work/school/daycare: \_\_\_\_\_

Kinds of materials exposed to at work/school: \_\_\_\_\_

#### Travel / Vacations

Do you travel frequently?  no  yes; if yes, to where? \_\_\_\_\_

#### Second Home (for patient living in two homes, please complete the following):

If patient is a child, parent/guardian in second home: \_\_\_\_\_ Time spent in second home: \_\_\_\_\_

Smokers: \_\_\_\_\_ Pets: \_\_\_\_\_

Other exposures: \_\_\_\_\_

List anything in the environment that you feel causes symptoms: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

I have reviewed page 1-8 with parent/patient.

Physician / PA Signature

Date \_\_\_\_\_