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PATIENT NAME: _____ DOB: _____

Requesting physician: _____

What are the problems that bring you to this practice? _____

CURRENT SYMPTOMS: Do you have? (Circle all appropriate answers.)

Eye Symptoms: none, itching, watering, redness, swelling, crusting, dryness, burning, dark circles, blurred vision, other _____

Ear Symptoms: none, itching, popping, congested, frequent infections, fluid in middle ear, blocked, hearing loss, earache, dizziness, other _____

Nasal Symptoms: none, sneezing, itching, sniffles, watery discharge, cloudy discharge, congestion, nosebleeds, loss of sense of smell/taste, polyps, frequent sinus infections, nasal dryness, snoring at night, other _____

Mouth and Throat Symptoms: none, sore throat, hoarseness, itchy throat, difficulty swallowing, swollen neck glands, mouth breathing, frequent strep throat, frequent tonsillitis, postnasal drip, bad breath/foul taste, other _____

Sleep History and Symptoms: none, weight gain within last 12 months _____ lb, snoring, grunting, witnessed stop breathing, restless night sleep, daytime sleepiness, poor memory and concentration, could fall asleep while driving, other _____

Headaches: none, infrequent, occasional, frequent, occur with sinus symptoms, sharp, dull, pounding, facial, forehead, temples, back of head, migraine, other _____

Chest Symptoms: none, chronic cough, chest tightness/congestion, wheezing, shortness of breath at rest/on exertion, wheeze/cough after exercise, sputum production, chest pain or pressure, heart murmur, sudden onset of difficulty breathing, coughed up blood, swollen legs, blue lips or fingernails, leg cramps when you walk, other _____

Stomach/Intestinal Symptoms: none, nausea and vomiting, bloating, loss of appetite, abdominal pain or cramping, diarrhea frequently, constipation frequently, pain or difficulty swallowing, heartburn or indigestion, queasy stomach, acid/bitter taste, cough upon lying down, other _____

Skin Symptoms: none, dry skin, hives, swelling, itchy skin, eczema, poison ivy/oak allergy, skin sensitivity to metals, chemicals, cosmetics, other _____

Insect Sting Reaction: none, large swelling, hives, difficulty breathing, throat swelling, dizzy, other _____
Stung by: bee, fire ant, yellow jacket, wasp, hornet, other _____

Which of the following do you think cause or make your symptoms worse? (Please check appropriate boxes.)

Trigger	Nose/Sinus Eyes/Ears Symptoms	Asthma/ Shortness of Breath Symptoms	Hives/ Eczema Symptoms	Stomach/ Intestinal Symptoms	Other
Parks/fields					
Mowed grass					
Gardening					
House dust					
Weather changes					
Windy days					
Humid days					
Hot days					
Cold days					
Air conditioning					
Forced air/heat					
Drafts					
Tobacco smoke					
Fumes/aerosols/sprays					
Cosmetics/perfumes					
Chemicals					
Soap powder					
Newspaper print					
Pets/animal exposure (list)					
Exercise					
Tension/excitement					
Clothing/fabrics					
Medicines (which)					
Milk/dairy products					
Beer/wines					
Certain foods (list)					
Menstrual periods					
URIs					
Other(s)					

Comments/explanation: _____

Insect stings:

	<u>Yes</u>	<u>No</u>
Do you have problems with insect stings?	()	()
Local swelling	()	()
Tongue or lip swelling	()	()
Scattered hives	()	()
Shortness of breath	()	()

Have you ever been treated in an emergency room for an insect sting? Yes No If so, describe: _____

Food allergies/sensitivities: Do you have problems with any food ingestants? If yes, describe problem. For instance: swelling or itching of tongue, lips, or mouth? Rashes or hives? Immediate or delayed vomiting or diarrhea?

Eggs _____	Fish _____
Wheat _____	Melon _____
Milk _____	Fruit _____
Cheese _____	Walnuts _____
Crab _____	Peanuts _____
Lobster _____	Tomatoes _____
Shrimp _____	Other _____

Drug allergies/sensitivities: Please list all medications that you have had an adverse reaction to and a description of that reaction.

<u>Medication Name</u>	<u>Type of Reaction</u>
_____	_____
_____	_____
_____	_____

Immunizations:

	<u>Yes</u>	<u>No</u>	DATE
DTP	()	()	_____
Hepatitis	()	()	_____
Tetanus	()	()	_____
Pneumovax/Prevnar 13	()	()	_____
Shingles vaccine	()	()	_____
Chicken pox	()	()	_____

PAST ILLNESSES: (Please check all illnesses you have had.)

<input type="checkbox"/> Rh fever	<input type="checkbox"/> Seasonal Allergies	<input type="checkbox"/> Hiatal Hernia/ Gastroesophageal
<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Nasal Polyps	<input type="checkbox"/> Reflux Disease
<input type="checkbox"/> Lyme Disease	<input type="checkbox"/> Sleep Apnea	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> Migraine HA	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Hypertension	<input type="checkbox"/> Exercise-induced Asthma Chronic	<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Diabetes Mellitus:	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Inflammatory Bowel Disease
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Emphysema/COPD	<input type="checkbox"/> Lactose Intolerant
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Pulmonary Fibrosis	<input type="checkbox"/> Irritable Bowel Syndrome
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Sarcoidosis	<input type="checkbox"/> Colon Cancer
<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Asbestosis	<input type="checkbox"/> Colon Polyps
<input type="checkbox"/> Thyroid:	<input type="checkbox"/> Tuberculosis or Positive Skin Test	<input type="checkbox"/> Diverticulosis/Diverticulitis
<input type="checkbox"/> Arthritis:	<input type="checkbox"/> Lung Cancer	<input type="checkbox"/> Pancreatitis
<input type="checkbox"/> Gout _____ (If other, please specify)	<input type="checkbox"/> Arrhythmia/palpitations	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Murmur	<input type="checkbox"/> Gallbladder Disease
<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Mononucleosis
<input type="checkbox"/> Raynaud's	<input type="checkbox"/> Valvular Heart Disease	<input type="checkbox"/> Nephritis
<input type="checkbox"/> Lupus (SLE)	<input type="checkbox"/> Congestive Heart Failure	<input type="checkbox"/> Urinary Tract Infection
<input type="checkbox"/> Pulmonary Emboli	<input type="checkbox"/> Angina/Coronary Artery Disease/	<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Myocardial Infarction	<input type="checkbox"/> Benign Prostatic Hypertrophy
<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Atherosclerotic Peripheral	<input type="checkbox"/> Prostate Cancer
<input type="checkbox"/> Pneumovax/Date Given: _____	<input type="checkbox"/> Vascular Disease	

Past Illnesses continued:

- | | | |
|---|--|---|
| <input type="checkbox"/> Polycystic ovaries | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seizure |
| <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Hemophilia | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Pelvic inflammatory disease/
sexually transmitted disease | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Lymphoma | <input type="checkbox"/> Nerve damage |
| <input type="checkbox"/> Uterine fibroids | <input type="checkbox"/> HIV | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Osteoporosis/osteopenia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Uterine cancer | <input type="checkbox"/> Atopic dermatitis | <input type="checkbox"/> Anxiety/neurosis |
| <input type="checkbox"/> Cervical cancer | <input type="checkbox"/> Seborrhea | <input type="checkbox"/> Multiple sclerosis |
| <input type="checkbox"/> Breast cysts | <input type="checkbox"/> Shingles | <input type="checkbox"/> Muscular dystrophy |
| <input type="checkbox"/> Breast cancer | <input type="checkbox"/> Psoriasis | <input type="checkbox"/> Meningitis |
| | <input type="checkbox"/> Hives | <input type="checkbox"/> Encephalitis |
| | <input type="checkbox"/> Cradle cap | <input type="checkbox"/> Attention deficit disorder or
attention deficit/hyperactivity |
| | <input type="checkbox"/> Skin cancer/type: _____ | <input type="checkbox"/> Other |

Hospitalizations (nonsurgical): Please list. _____

Surgeries: Please list. _____

Injuries: Please list. _____

Medications: Please list all medications that you are currently taking, dosage, frequency, and for what condition.

MEDICATION NAME/DOSAGE	FREQUENCY	FOR WHAT CONDITION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY:

Family Member	Sex	Age	Alive/ Deceased	Medical Problems (List all.)
Mother	F	_____	_____	_____
Father	M	_____	_____	_____
Siblings	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Children	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

SOCIAL HISTORY:

() Single () Married () Divorced () Widowed () In a relationship

Occupation(s) of patient: _____

Occupation(s) of spouse/sig. other: _____

Occupation(s) of mother: _____

Occupation(s) of father: _____

Does patient drink alcoholic beverages? () Yes () No Type: _____

Frequency: _____

Cigarette use: Yes/No Age began: _____ Age quit: _____ Peak amount: _____ Average: _____

If you still smoke, do you want to stop? () Yes () No

Does anyone in the home smoke? () Yes () No

() pipe () cigarette () cigar How much? _____

Caffeine consumption? () Yes () No Coffee/tea/soda? How much? _____

Hobbies: _____

Exercise: _____

Environment:

How long have you lived in New England? _____

Prior state(s)? _____

Location of home () Rural () Suburb () City

Type of home () Apartment () Frame house () Brick () Condo () Mobile home

Heating/AC () Forced air () Steam () Radiant heat

System () Forced hot water () Electric () Woodstove/pellet

() Air conditioning () Air purifier () Fireplace: gas/wood
(window/central)

How old is dwelling: _____

How long lived there? _____

Basement () Yes () No

Is basement () Dry () Damp

Dehumidifier () Yes () No

Humidifier () Yes () No

What is basement used for? _____

() Finished

Animals:

Do you have any pets? List. _____

How long have these pets been with you? _____

Does the animal have full range of the house? _____

Does the animal sleep on the patient's bed? _____

Does animal exposure make symptoms worse? _____

Patient's bedroom:

Floor Covering		Walls	Window Coverings		
Carpeting w/pad	()	Wallpaper	()	Washable curtains	()
Carpeting w/o pad	()	Pictures	()	Non-washable curtains	()
Rug w/pad	()	Pennants	()	Blinds	()
Rug w/o pad	()	Tapestries	()	Other _____	()
Throw rug	()	Other _____	()		
Linoleum	()				
Hardwood	()				
Other _____	()				

Closet	Pillow	Mattress			
None	()	Age _____ years			
Door kept open	()	Type: _____			
Door kept closed	()	Feather	()	Innerspring cotton	()
Used for storage	()	Foam rubber	()	Foam rubber	()
Seasonal clothes	()	Synthetic	()	Other _____	()
		Hypoallergenic cover	()	Hypoallergenic cover	()

Any houseplants in bedroom? _____ Upholstered furniture? _____

What is bedding made of? (Down comforters, wool blankets, quilts, etc.) _____

Travel:

Do you feel better when traveling outside of New England? () Yes () No

REVIEW OF SYMPTOMS AND SYSTEMS: (Please circle all symptoms you have.)

Constitutional: Lack of energy, daytime sleepiness, trouble sleeping, snoring, loss of appetite, weight changes, fevers, fatigue, chills, night sweats.

Headaches: Forehead, temples, back of head, top of head, behind eyes, facial.

Eyes: Eye problems, such as double or blurred vision, loss of vision, glaucoma, cataracts, wears contact lenses, glasses, dentures.

Ears: Hearing problems, buzzing/ringing in ears, hearing aids.

Nose: Sinus infections, broken nose, nosebleeds, loss of smell/taste.

Mouth and Throat: Sore, itchy, difficulty in swallowing, swelling of lips or tongue, swollen neck glands.

Respiratory System: Shortness of breath, wheezing, coughing.

Cardiovascular System: High blood pressure, palpitations/arrhythmia, chest pain/tightness.

Gastrointestinal System: Change in bowel habits, choking on food, bloody or tarry stools, jaundice, abdominal pain, nausea or vomiting, diarrhea, constipation.

Renal/Reproductive: Frequency, infections, stones, bladder.

Men: Prostate problems, nighttime urination.

Women: Abnormal menstrual periods, pregnant.

If you are a woman are you past/peri-menopause Yes/No If so, at what age? _____

Do you take estrogen replacement/birth control pills? Yes/No

Endocrine: Thyroid disorder, diabetes, excess thirst, hunger or urination.

Hematology: Bleeding, easy bruising, anemia.

Immune System: Frequent infections, risk factors for HIV, cancer.

Musculoskeletal System: Joint pain, swelling or redness, arthritis, back pain. Muscle aches or tenderness, gout, weakness, tremors.

Skin: Rash, itching or other skin problems.

Neurological: Paralysis (even temporary), seizures, stroke, numbness, loss of balance, history of falls, loss of memory, headaches, loss of consciousness.

Psychiatric: Unusual thoughts, nervousness, crying or sadness, depression, anxiety.