CAARD
CENTER FOR ASTHMA, ALLERGY AND RESPIRATORY DISEASE, PLLC

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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:

	Yes	No
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.

Medication Name	**Type of Reaction**

Immunizations:

	Yes	No	DATE
DTP	◯	◯	
Hepatitis	◯	◯	
Tetanus	◯	◯	
Pneumovax/Prevnar 13	◯	◯	
Shingles vaccine	◯	◯	
Chicken pox	◯	◯	

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

- ☐ Rh fever
- ☐ Scarlet Fever
- ☐ Lyme Disease
- ☐ Migraine HA
- ☐ Hypertension
- ☐ Diabetes Mellitus: Type 2
- ☐ Hyperlipidemia
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Macular Degeneration
- ☐ Thyroid: Hypo
- ☐ Arthritis: Other _____ (If other, please specify)
- ☐ Gout
- ☐ Bursitis
- ☐ Fibromyalgia
- ☐ Raynaud's
- ☐ Lupus (SLE)
- ☐ Pulmonary Emboli
- ☐ Pneumonia
- ☐ Pleurisy
- ☐ Pneumovax/Date Given: _____
- ☐ Seasonal Allergies
- ☐ Nasal Polyps
- ☐ Sleep Apnea
- ☐ Asthma
- ☐ Exercise-induced Asthma Chronic
- ☐ Bronchitis
- ☐ Emphysema/COPD
- ☐ Pulmonary Fibrosis
- ☐ Sarcoidosis
- ☐ Asbestosis
- ☐ Tuberculosis or Positive Skin Test
- ☐ Lung Cancer
- ☐ Arrhythmia/palpitations
- ☐ Murmur
- ☐ Atrial Fibrillation
- ☐ Valvular Heart Disease
- ☐ Congestive Heart Failure
- ☐ Angina/Coronary Artery Disease/ Myocardial Infarction
- ☐ Atherosclerotic Peripheral Vascular Disease
- ☐ Hiatal Hernia/ Gastroesophageal Reflux Disease
- ☐ Peptic Ulcer Disease
- ☐ Ulcerative Colitis
- ☐ Crohn's Disease
- ☐ Inflammatory Bowel Disease
- ☐ Lactose Intolerant
- ☐ Irritable Bowel Syndrome
- ☐ Colon Cancer
- ☐ Colon Polyps
- ☐ Diverticulosis/Diverticulitis
- ☐ Pancreatitis
- ☐ Hepatitis
- ☐ Gallbladder Disease
- ☐ Mononucleosis
- ☐ Nephritis
- ☐ Urinary Tract Infection
- ☐ Kidney Stones
- ☐ Benign Prostatic Hypertrophy
- ☐ Prostate Cancer

Past Illnesses continued:

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

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 System
(◯) Forced air (◯) Steam (◯) Radiant heat
(◯) Forced hot water (◯) Electric (◯) Woodstove/pellet
(◯) Air conditioning (window/central) (◯) Air purifier (◯) Fireplace: gas/wood

How old is dwelling: _____ How long lived there? _____

Basement (◯) Yes (◯) No What is basement used for? _____
Is basement (◯) Dry (◯) Damp (◯) Finished
Dehumidifier (◯) Yes (◯) No
Humidifier (◯) Yes (◯) No

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		Age _____ years	
Door kept open	◯	Type:		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.