Allergy and Asthma Center of Montana
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NEW PATIENT HISTORY

AGE:_____
REFERRING PHYSICIAN_____PHONE #: ( )_____ - _____
REFERRING PHYSICIAN ADDRESS:
_____
_____

REASON FOR TODAY'S VISIT:
_____
_____
_____
_____

DRUG ALLERGIES	REACTION

This questionnaire is divided into sections based on your possible different allergic problems. Please fill out as best you can the sections that apply to your conditions.

FORM COMPLETED BY:_____DATE:_____

CURRENT MEDICATION LIST

NAME OF MEDICATION	DOSE / STRENGTH	HOW OFTEN

OVER THE COUNTER/ VITAMIN / HERBAL SUPPLEMENTS

NAME OF MEDICATION	DOSE / STRENGTH	HOW OFTEN

Please circle all that apply to your allergic nose, eye, throat or ear symptoms:

Nasal itching	Sneezing	Post nasal drip		
Nasal congestion	Nasal drainage	Sore throat	Throat itching	Hoarse voice
Ear pain/ pressure	Ear popping	Ear itching	Hearing changes	
Fluid behind ears	Ear ringing	Ear drainage	Dizziness	
Eye redness	Eye itching	Eyelid swelling	Eye watering	
Eye pain	Vision changes	Dark circles under eyes		
Loss of taste or smell		Sinus pain		

If **YES** to any of the above questions, how long have these symptoms been present?

_____

_____

If **YES** to any of the above questions, how often do your symptoms occur (# of times per day, week, etc.,)

Are your symptoms worse at any particular time of the year? (circle one) **YES** **NO**

If YES, **Please circle which months are worse,**

January	February	March	April	May	June
July	August	September	October	November	December

Symptoms are worse: **(Check all that apply)**

___At home ___At school ___At work

___Indoors ___Outdoors ___Other Location_____

Please **Mark any** of the following that make your **symptoms worse.**

___Fresh cut grass	___High pollution days
___Dust	___Air conditioning
___Damp areas	___Smoke
___Entering a basement	___Cats
___House plants	___Dogs
___Barns/hay	___Other animals_____
___Wet weather	___Soap
___Dry weather	___Perfumes
___Wind	___Paint fumes
___Hot day	___Chemical odors
___Cold day	___News papers
___Weather change	___Other strong odors_____

What medications have you tried for treatment of you symptoms? Indicate if you think the medication improved your symptoms.

Medication	**Result**

Have you ever been evaluated by an allergist? (Circle one) **YES** **NO**
If YES, who was your previous allergist?_____
Have you ever had allergy skin testing or blood testing done? (Circle one) **YES** **NO**
If YES, what were the positive reactions?_____
_____

IF POSSIBLE, PLEASE BRING IN PREVIOUS ALLERGY RECORDS OR HAVE THESE SENT TO OUR OFFICE FOR YOUR VISIT.

Have you ever been treated with allergy shots? (Circle one) **YES** **NO**
If YES, did the allergy shots help you? (Circle one) **YES** **NO**
What years were the shots taken?_____
Did you have any serious reactions to the shots? **YES** **NO**
If YES, please explain_____
_____
_____

Have you had any problems after eating certain foods? (Circle one) **YES** **NO**
If YES, please write down the type of food, and the type of reaction below:

Food	**Reaction**

Have you been diagnosed with asthma? **YES** **NO**
If yes, how often do you use your rescue medicine (for example Albuterol)?_____
Do you have problems with any of the following?
COUGH? **YES** **NO**

COUGHING UP MUCUS OR PHLEGM? **YES** **NO**

WHEEZING? **YES** **NO**

SHORTNESS OF BREATH? **YES** **NO**
At rest? **YES** **NO** With activity **YES** **NO**
COUGHING UP BLOOD FROM YOUR LUNGS? **YES** **NO**

Is your coughing, wheezing or shortness of breath worse at certain times of the year? **YES** **NO**
If YES, please specify which months. **Please circle all that apply.**

January February March April May
June July August September October
November December

What seems to trigger your coughing, wheezing or shortness of breath? **Please circle your answer.**

Exposure to:

Cold	Heat	Humidity	Quick weather changes	Smoke
Dust	Mold	Grass	Weeds	Strong odors
Cats	Dogs	Other animals_____		Physical activity
Upper respiratory infections		Other_____		

DO YOU HAVE TROUBLE WITH CHEST PAIN? **YES NO**

If YES, is it: Sharp Dull Tight Pressure Stabbing

Where is the pain specifically located_____

How long have you had this pain? _____# days_____# weeks_____# years

PULMONARY TEST RESULTS

Have you ever had:

Chest X-ray?	**YES** **NO**	IfYES, when?_____	where?_____
Chest CAT scan	**YES** **NO**	IfYES, when?_____	where?_____
Breathing test? (PFT)	**YES** **NO**	IfYES, when?_____	where?_____
Sleep study?	**YES** **NO**	IfYES, when?_____	where?_____
Exercise test?	**YES** **NO**	IfYES, when?_____	where?_____

Have you ever had hives, urticaria, welts or problems with swelling of your lips, tongue, throat, hands or feet?

YES NO If YES, please describe:

_____

_____

_____

Have you had any reactions after an insect bite or bee, wasp, yellow jacket, hornet or fire ant sting?

YES NO If YES, please describe:

_____

_____

_____

Have you ever had problems after exposure to latex (gloves, balloons, rubber products, condoms, etc.)?

YES NO If YES, please describe:

_____

_____

_____

Do you have a history of eczema or atopic dermatitis?

YES NO If YES, please describe where you get a rash and what treatment has been tried.

_____

_____

Have you ever had contact dermatitis? (A rash after something touches your skin, such as certain metals or poison ivy)
YES NO If YES, Please describe.

_____
_____
_____

Have you ever had a reaction after an immunization/vaccine?
YES NO If YES, please describe._____
_____

PAST MEDICAL HISTORY

Please Circle all that apply to your past or current medical history

Allergies/hay fever
Anemia
Aneurysm
Arthritis
Asthma/Wheezing
Back pain-recurrent
Bleeding tendencies/ bruise easily
Blood clots
Bronchitis
Cancer, type_____
Cataracts
Chest injury
Collapsed lung
Convulsions/Seizures
COPD/Emphysema/chronic bronchitis
Cystic Fibrosis
Depression
Diabetes
Endometriosis
Glaucoma
Heart attack
Heartburn/reflux
Heart failure Heart valve problems
Heart valve problems
Hepatitis/liver disease
Herpes
High blood pressure
High cholesterol
HIV positive or AIDS
Irregular heart beat
Kidney disease
Lupus
Meningitis/brain infection
Migraine headaches
Neurological problems
Nasal or sinus polyps
Osteoporosis
Pleural fluid/effusion
Pneumonia
Polio
Prostate problems
Psychiatric problems
Recurring infections
Rheumatic fever
Rheumatoid arthritis
Sinus infections
Sleep apnea
Skin infections
Stomach ulcers
Thyroid disease
Stroke
Tuberculosis (TB)
Ulcers
Varicose veins
Venereal disease

Have you ever been on a ventilator (life support breathing machine) **YES NO**
If YES, when and for what?_____

Do you have other conditions requiring regular medical attention?

Problem	**Year**

PAST SURGICAL HISTORY
List all surgeries since birth

Surgery

Have you ever received immunizations for the following:
Influenza? **YES** **NO** Year immunized?_____
Pneumonia? **YES** **NO** Year immunized?_____

Have you ever been exposed to anyone that you know who had TB? **YES** **NO**
Have you ever had a **positive** TB skin test? **YES** **NO**

CIRCLE ANY AND ALL FINDINGS THAT APPLY TO YOU VERY RECENTLY

GENERAL:
Fever Sweats Fatigue Recent appetite change Recent weight gain #_____pounds
Recent weight loss#_____pounds Formula feeding Breast feeding
SKIN:
Rash Rash in the sun Sensitive or itchy skin Hair loss Mole change
BLOOD:
Bleeding easily Bruise easily Swollen glands
ENDOCRINE / METABOLIC:
Frequent urination Frequent drinking Cold intolerance Heat intolerance Chronic steroid therapy
EYE:
Light sensitivity Blurred vision Diminished vision Vision loss Eye irritation
EAR /NOSE / THROAT:
Snoring Mouth/tongue sores Change in voice Nose bleeds
Hearing loss Ringing in ears Sinus pain
CARDIOVASCULAR:
Fainting Chest pain Leg swelling Palpitations Shortness of breath lying flat

GASTROINTESTINAL / LIVER:
Abdominal pain Blood in stool Constipation Diarrhea
Pain with swallowing Difficulty swallowing Heartburn Nausea Vomiting
RENAL / URINARY:
Blood in urine Difficulty urinating Frequent urination
Nighttime urination Incontinence Decreased stream Hesitancy
MUSCULOSKELETAL:
Joint pain Joint stiffness Joint swelling Muscle ache
NEUROLOGICAL:
Double vision Seizures Numbness/tingling Dizziness
Memory loss Headache
PSYCHOLOGICAL:
Personality change Anxiety Depression Suicidal thoughts
High stress level Sleep disturbance
MALE GENITAL-REPRODUCTIVE:
Infertility Erectile dysfunction
FEMALE GENITAL-REPRODUCTIVE:
Breast pain Nipple discharge Frequent yeast infections Infertility Contraception

YOUR SOCIAL HISTORY AND HABITS

Have you ever used any of the following?

- Cigarettes _____ packs/day _____# of years.
- Pipe _____hours/day _____# of years.
- Cigars _____number/day_____# of years.
- Chewing tobacco
- Snuff

Are you currently smoking? **YES** **NO** If previous smoker, year quit?_____
Interested in stopping? **YES** **NO**
Have you had significant exposure to other people smoking cigarettes? **YES** **NO**
If YES, who, how much and for how long?
_____
_____

- Alcohol: Type:_____Amount:_____How often_____
- Street drugs: (including Cocaine, Marijuana, Heroin or Meth)

What:_____When:_____How often_____

Occupation_____

Marital Status: Married Single Divorced Widowed Other

Any work exposure to asbestos, hard rock mining, factory, flour, chemicals, welding etc.? **YES** **NO**
If YES, what :_____When:_____
Have you ever lived outside of Montana? **YES** **NO**
If YES, where:_____when:_____
how long_____

FAMILY MEDICAL HISTORY
(Check all that apply)

	Father	Mother	Children	Brother	Sister	Other blood relative
Allergies/ Hay fever						
Angioedema (allergic swelling)						
Arthritis						
Asthma						
Bleeding disorder						
Blood clots						
Cancer						
Cystic fibrosis						
COPD/Emphysema/Chronic bronchitis						
Diabetes						
Eczema						
Heart disease						
High blood pressure						
Hives (Urticaria)						
Immunodeficiency (recurrent infections)						
Interstitial lung disease						
Kidney disease						
Lupus						
Pulmonary fibrosis						
Rheumatoid arthritis						
Stroke						
Other:						

This next section should be filled out as completely as possible to help your physicians better assess your condition. This portion will tell us about other possible areas which could be causing you discomfort.

In what type of dwelling do you live? Please **circle** your answer.

House Town house Condominium
Apartment Flat Mobil home

What is the age of your dwelling? _____years old
How long have you lived there? _____years_____months

Circle the one best answer: Your dwelling is built over:

A crawl space A cement slab A full basement
A partial basement and crawl space A partial basement and cement slab

Describe the basement or crawl space: **Circle more than one if applicable.**

Wet Has a musty odor Has a cement floor
Dry Never musty Has a tiled floor
Sometimes wet or damp Has a carpeted floor
Is covered with plastic sheeting

What type of fuel do you use for heating? **Circle more that one if applicable.**

Natural gas Electric Wood Fuel oil

What type of heat system does your home have? **Please circle you answer.**

Forced air Baseboard hot water Steam radiators Central stove or heater
Electric radiators or heater Heat pump

Please **circle any** of the following that you use in your home:

Central air conditioning Room air conditioning Swamp cooler Ceiling fans
Window fans Dehumidifier Humidifier (central/portable)
Steam vaporizer Cool mist vaporizer Central air cleaner Room air cleaner

How many house plants are in the home?_____

How many arrangements of dried flowers are there in the home?_____

Where does mildew or mold (usually black) tend to appear? **Circle any that apply**

Have never seen any Bathroom grout Basement Bathroom shower curtain
Closets Elsewhere in the bathroom Laundry area
Other rooms_____

Have you ever seen any cockroaches in your home? **YES** **NO**

Do you have any pets in your home? **Please circle all that apply** and indicate how many you have, and how long you have had the pet in your home.

Pet	**How many**	**How long**	**Hours/day spent in the home**
Cats			
Dogs			
Birds			
Hamsters			
Guinea pigs			
Gerbils			
Rats			
Mice			
Rabbits			

Other animal exposure (indoor or outdoor):

_____

_____

What type of pillow is used? **Circle the one best answer.**

Foam Dacron Feather Other synthetic

Is the pillow encased in a plastic/special dust mite protective material? **YES** **NO**
Is the mattress encased in a plastic/special dust mite protective material? **YES** **NO**
Are the box springs encased in a plastic/ special dust mite protective material? **YES** **NO**

OCCUPATIONAL EXPOSURE
(Complete only if your symptoms are related to work exposure)

Employers name:_____ Job title:_____
Date job began: _____Date job ended: _____Duration:_____
Industrial process:_____
Describe job activity

_____
_____
_____
_____

List materials used:

_____
_____
_____

Estimate of intensity of exposure: SLIGHT MODERATE GREAT
Explain:

_____
_____
_____

Was respiratory protection used? All the time Sometimes Rarely Never
List materials used by adjacent workers:

_____
_____
_____

Estimate of ventilation/exhaust status Good Fair Poor
Explain: _____
Part-time jobs/ hobbies: **YES** **NO**
Explain: _____

CLINICAL INFORMATION

Any symptoms related to above? **YES** **NO**
Explain:_____
Time interval between job began and symptoms developed:_____
Relationship between work and symptoms? **YES** **NO**
Explain: _____
Time off work due to illness: **YES** **NO**
Number of days off: _____
Explain: _____
Other workers affected? **YES** **NO**
Explain:

_____
_____

Exams before employment and / or while working? **YES** **NO**
Explain:

_____
_____

EAB 1-30-15