ALLERGY and ASTHMA CENTER
Living Without Limitations

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Health History Form

Please answer ALL questions

Patient Name: _____ Date: _____

Reason for today's visit: _____

Date of Birth: _____Age: _____ Referring Provider: _____

Symptoms (Check all that apply)

Ears, Nose and Throat											
Congestion	☐	Throat drainage	☐	Face pain	☐	Loss of taste	☐	Ear infections	☐
Runny nose	☐	Itchy nose	☐	Teeth pain	☐	Loss of smell	☐	Sinus infections	☐
Sneezing	☐	Mouth breathing	☐	Snoring	☐	Hoarseness	☐	Headaches	☐
Sore throat	☐	Nosebleeds	☐	Ear pain	☐	Ear congestion	☐	Hearing loss	☐
Other:									
Eyes									
Redness	☐	Itching	☐	Burning	☐	Watering	☐	Vision changes	☐
Drainage	☐	Swelling	☐	Other:					
Chest									
Cough	☐	Shortness of breath	☐	Wheeze	☐	Throat tightness	☐	Dizziness	☐
Chest tight	☐	Difficulty breathing	☐	Chest Pain	☐	Chest congestion	☐	Stridor	☐
Other:									
Worse with:		Night time	☐	Day time	☐	Outdoors	☐	Cold/dry air	☐
Hot/humid air	☐	Exertion	☐	Strong smells	☐	Anxiety	☐	"Colds"/infections	☐
Other:									
Better with:		Inhalers	☐	Cough Syrup	☐	Rest	☐	Lying down	☐
Other complaints:									

Medications:	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Medication Allergies	
Name of Medication	**Type of Reaction**

Medical History							
	Asthma		Thyroid Disease		Emphysema	Other:	
	Seasonal Allergies		Psoriasis		Sleep Apnea		
	Food Allergy		Stomach/Acid Reflux		Kidney Disease		
	Eczema		High Blood Pressure		Depression		
	Hives		Diabetes		Anxiety		
Surgeries:					**Date:**		

Family History			
Condition:	**Affected Family Members**	**Condition:**	**Affected Family Members**
Asthma		Cystic Fibrosis	
Seasonal Allergies		Emphysema/COPD	
Food Allergies		Thyroid Disease	
Hives		Diabetes	
Eczema		Other:	

Environmental History

I live in a: [ ] House [ ] Apartment [ ] Duplex [ ] Mobile Home/Trailer

Age of Home: _____ How long have you lived there? _____

Type of Heat: [ ] Forced Air [ ] Wood burning [ ] Hot water [ ] Electric [ ] Pellet stove

Air conditioning: [ ] Central [ ] Window/Wall [ ] None Air Cleaner Type: _____Humidifier/Dehumidifier?_____

% of home carpeted: _____ Patient's room carpeted? _____ Known mold or mildew? _____

What pets do you have in the home? _____ Are they in the patient's bedroom? _____

Does anyone smoke at home? Y/N Who?

Patient is a: [ ] Smoker : ____packs/day [ ] Non-smoker [ ] Quit smoking in: _____ Smokeless Tobacco?_____

Review of Systems	**Mark any that all that apply**	**(over the last 4-6 weeks)**	
General	Ear, Nose and Throat	Eyes	Respiratory
○ Weight gain/loss	○ Nasal polyps	○ Vision changes	○ Bronchitis
○ Fever/chills	○ Hearing problems	○ Glaucoma	○ Pneumonia
○ Night sweats	○ Ringing in ears	○ Eye pain	○ Productive cough
○ Poor appetite	○ Voice changes	○ Eye discharge	○ Coughing up blood
○ Weakness	○ Recurrent Strep	○ Circles under eyes	○ Pain with breathing
Skin:	Cardiology	Gastro-intestinal	Musculoskeletal
○ Rash	○ Chest pain	○ Heartburn	○ Joint stiffness
○ Sensitive skin	○ Palpitations	○ Vomiting	○ Joint swelling
○ Easy bruising	○ Leg swelling	○ Diarrhea	○ Joint pain
○ Swelling	○ Fainting	○ Bloody stools	○ Muscle pain
○ Reaction to latex	○	○ Stomach pain	○ Jaw pain
Neurology	Blood/Lymph	Endocrine	Kidney
○ Headache	○ Swollen glands	○ Excessive sweating	○ Kidney stones
○ Migraine	○ Fatigue	○ Excessive thirst	○ Excessive urination
○ Seizures	○ Clotting problems	○ Heat intolerance	○ Decreased urination
○ Memory loss	○ Anemia	○ Cold intolerance	○ Incontinence