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Medical History Form

Date of Visit:

Chief Complaint:
What is the reason for your visit:
What is the symptoms that bothers you the most:
What do you expect to get out of your visit:
Section 2: History of “Hay Fever” or Nasal Allergy Symptoms
Check all the symptoms that you have had: 〔〕 stuffy nose/congestion runny nose 〔〕 itchy nose 〔〕 frequent sneezing 〔〕 postnasal drip/ dripping at the back of the throat 〔〕 itchy eyes 〔〕 watery eyes 〔〕 cough 〔〕 itchy throat 〔〕 itchy ears 〔〕 blocked ears
How many years ago did you start experiencing these symptoms:
Do you experience these symptoms year round? 〔〕 yes 〔〕 no If no, which month or months are worse?
Which triggers make your nasal or eye symptoms worse? 〔〕 tree pollen 〔〕 grass pollen 〔〕 weeds 〔〕 molds 〔〕 dust 〔〕 cats 〔〕 dogs 〔〕 tobacco smoke 〔〕 fumes or perfumes 〔〕 dry or cold air 〔〕 no clear trigger 〔〕 others, specify:
Have you been previously tested for allergies? 〔〕 no 〔〕 yes if yes when and where? Check all the results that were positive: 〔〕 trees 〔〕 grasses 〔〕 weeds 〔〕 molds 〔〕 dust mites 〔〕 cats 〔〕 dogs 〔〕 cockroach
Have you been treated with allergy shots? 〔〕 no 〔〕 yes if yes, when and where and for how long?
What medications have you used for your condition?
over the counter antihistamines: 〔〕 benadryl 〔〕 claritin 〔〕 zyrtec 〔〕 allegra 〔〕 others specify:
over the counter oral decongestants: 〔〕 sudafed 〔〕 others: specify:
over the counter nasal decongestant spray: 〔〕 afrin 〔〕 others: specify:
prescription antihistamines: 〔〕 xyzal
prescription nasal spray: 〔〕 astelin 〔〕 flonase 〔〕 nasacort 〔〕 nasonex 〔〕 rhinocort 〔〕 veramyst 〔〕 dymista 〔〕 qnasl 〔〕 others, please specify:
Which medications were definitely helpful:
Which medications were somewhat helpful:
Which medications were not at all helpful?
Did any of the medications have side effects? 〔〕 no 〔〕 yes, specify:

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Section 3: History of Sinus Infections

Have you ever had a sinus infection treated with antibiotics? [ ] yes [ ] no (if no skip to section 4)

Which antibiotics have you been treated with for sinusitis: [ ] amoxicillin [ ] augmentin [ ] avelox [ ] bactrim [ ] biaxin [ ] ceftin [ ] azithromycin/z-pac/zithromax [ ] levaquin [ ] others, specify:

Approximately how many times a year have you been treated with antibiotics for sinusits?

When was the last time you were treated for sinusitis? By whom?
Which medication? For how long?

Check all the symptoms of sinusitis you've had: [ ] pressure on the forehead [ ] pressure behind the eyes [ ] pressure on the cheek area [ ] yellow or green nasal secretions [ ] sore throat [ ] fatigue [ ] fever

Have you ever had a CT scan of your sinuses? [ ] no [ ] yes If yes when was it done and what was the result?

Have you ever had surgery on your nose or sinuses? [ ] no [ ] yes If yes when was it done and what was the outcome?

Have you ever been diagnosed with nasal polyps? [ ] no [ ] yes If yes, when?

Section 4: History of Asthma or Chest Symptoms

Check all the symptoms you have ever had: [ ] shortness of breath [ ] wheezing [ ] cough [ ] chest tightness
[ ] none of the above (skip to section 5)

How many years ago did you start to experience these symptoms?

Do you experience these symptoms year round? [ ] No [ ] Yes

Check all the seasons when your chest symptoms get worse [ ] spring [ ] summer [ ] fall [ ] winter

Check all the triggers that make your chest symptoms worse: [ ] tree pollen [ ] grass pollen [ ] weeds [ ] molds [ ] dust [ ] cats [ ] dogs [ ] tobacco smoke [ ] fumes or perfumes [ ] dry or cold air [ ] respiratory infections [ ] exercise [ ] aspirin, ibuprofen or similar drugs [ ] no clear trigger [ ] others, specify:

Have you ever been diagnosed with asthma? [ ] no [ ] yes If yes, when?

Have you previously had a breathing test for asthma? [ ] no [ ] yes If yes, when was it done and what was the result?

Check all the medications you have ever used for asthma:
prescription bronchodilator inhaler: [ ] albuterol [ ] maxair [ ] proventil [ ] proair [ ] serevent [ ] xopenex
prescription steroid inhaler [ ] advair diskus or HFA [ ] asmacort [ ] asmanex [ ] flovent [ ] pulmicort [ ] symbicort [ ] aerospan
prescription oral medications [ ] prednisone [ ] medrol [ ] singulair [ ] theophylline
[ ] others, please specify

Which medications were definitely helpful?

Which medications were somewhat helpful?

Which medications were not at all helpful?

Which medications had side effects and what were they?

Have you ever been treated in the Emergency Department for an asthma attack? [ ] no [ ] yes

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if yes, how many times total? When was the last time?

Have you ever been admitted to the hospital for an asthma attack? [ ] no [ ] yes
if yes, how many times total? When was the last time?

Over the past month, how frequently did you have chest symptoms?

Over the past month, how frequently did you wake up because of chest symptoms?

Have you been experiencing difficulty in performing physical activities because of chest symptoms? [ ] no [ ] yes

Section 5: History of other possible allergic conditions:

Have you ever had an reaction to food? [ ] no [ ] yes If yes please provide details, use a separate sheet if needed:

Have you ever had recurrent hives or swelling? [ ] no [ ] yes If yes please provide details, use a separate sheet if needed:

Have you ever had other problems possibly related to allergy? [ ] no [ ] yes If yes please provide details, use a separate sheet if needed:

Have you ever had an allergic reaction to: [ ] latex [ ] contrast [ ] stinging insect

Section 6: Past Medical and Surgical History

Have you ever been diagnosed with any of the following: If yes, please write down when you were diagnosed:

[ ] cataracts	[ ] migraine headache
[ ] glaucoma	[ ] thyroid disorder
[ ] diabetes	[ ] peptic ulcer disease or acid reflux disease
[ ] eczema or other skin condition	[ ] pneumonia or abnormal chest x-ray
[ ] high blood pressure	[ ] sleep apnea
[ ] irregular heart beat	[ ] any other medical condition, specify:
[ ] prostate enlargement	

Have you ever had any of the following surgeries? If yes, please write down when you had the operation:

[ ] sinus surgery	[ ] adenoidectomy
[ ] removal of nasal polyps	[ ] ear tube placement
[ ] repair of deviated nasal spetum	[ ] any other operations, specify:
[ ] tonsillectomy	

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Section 7: Current or Recent Medications

Write details of all the prescription and over-the-counter medications that you have used over the past month.
[ ] check this box if you have not been taking any prescription or over-the-counter medications over the past month

Name of Drug	Dose	Frequency

Section 8: Allergic and other Adverse Drug Reactions

Write details of any allergic or adverse reaction to a drug.
[ ] Check this box if you have had no adverse reactions to any drug

Name of Drug	Description of adverse drug reaction and when it occurred:

Section 9: Social History

Marital Status: [ ] single [ ] married [ ] divorced [ ] widowed How many children do you have?

Have you ever smoked cigarettes [ ] never [ ] yes CURRENTLY smoke ______ packs per day started in ___________
[ ] yes USED to smoke __________ packs per day started in year:_____________ stopped ______________

Occupation:

Hobbies:

Section 10: Family Medical History
Does anyone in your immediate family have allergies or asthma? [ ] no [ ] yes If yes, specify who and what condition they have:
Section 11: Environmental History
In what city/state were you born and raised:
In what city/state do you live now? Since when?
How old is your home? How long have you lived there?
Check the type of your home: [ ] single family house [ ] apartment [ ] condominium [ ] townhouse Number of bedrooms:
Check all of the items in your home: [ ] forced warm air heating or central furnace [ ] radiator heating [ ] wood stove [ ] central air conditioning [ ] window air conditioning unit [ ] HEPA Filter [ ] humidifier [ ] dehumidifier
Check all the items in your bedroom: [ ] wall to wall carpeting [ ] area rugs [ ] heavy curtains [ ] wood or hard flooring [ ] stuffed animals [ ] decorative pillows Check all the items that you use: [ ] foam pillows [ ] fiber filled pillows [ ] feather pillows [ ] standard bed mattress [ ] water bed [ ] dust mite proof covers for circle: pillows mattress box spring
Do you have cats at home? [ ] no [ ] yes If yes, specify how many and since when: Does the cat go to your bedroom? [ ] no [ ] yes If yes, does it sleep on your bed? [ ] no [ ] yes
Do you have dogs at home? [ ] no [ ] yes If yes, specify how many and since when: Does the cat go to your bedroom? [ ] no [ ] yes If yes, does it sleep on your bed? [ ] no [ ] yes
Do you have mold or water damage at home? [ ] no [ ] yes
Do you have cockroaches at home? [ ] no [ ] yes
Are you exposed to cats or dogs at home or other homes that you visit or at work? [ ] no [ ] yes
Are you exposed to other fur-bearing animals or irritants at home or at work? [ ] no [ ] yes
Section 12: Review of Systems
Please check all of the signs or symptoms you have had
General: [ ] fatigue [ ] difficulty sleeping Eyes: [ ] use of eye glasses or contacts [ ] itchy yes [ ] watery eyes
Ear/Nose/Throat [ ] hearing loss [ ] ringing in the ears [ ] ear ache [ ] hoarseness [ ] nasal bleeding
Cardiovascular: [ ] palpitations [ ] heart murmur Gastrointestinal: [ ] abdominal pain [ ] acid reflux
Genitourinary [ ] difficulty urinating Skin: [ ] hives [ ] skin itching [ ] other rashes, specify:
Neurologic: [ ] dizziness [ ] headache Hematologic: [ ] anemic
[ ] Check this box if none of the above
Additional Notes: