Allergy & Asthma Consultants of Mid-Michigan, P.C.

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Adult Allergy & Medical History

How did you hear about our office?

____Referral by another physician ____Referral by another patient
____Phonebook listing _____ Internet Ad; Please circle one Google, Bing or Yahoo
____Other: _____

Name:_____ Birth Date:_____

Reason you were sent to an Allergist:_____

_____

Prior allergy tests (date & where):_____

Prior allergy injections (date & where):_____

Prior Chest x-ray/CT (date & where):_____

Do you now or have you had any problems related to the following? Circle Yes or No.

Diabetes	Y	N	Hypertension (high or low blood pressure)	Y	N
Cancer	Y	N	Stroke	Y	N
Convulsions	Y	N	Heart Disease	Y	N
Asthma	Y	N	Arthritis/Gout/Rheumatism	Y	N
Lung disease	Y	N	Blood Disease	Y	N
Kidney Disease/Stones	Y	N	Peptic Ulcer/ GERD	Y	N

Constitutional symptoms

Fever	Y	N
Night sweats	Y	N
Weight change	Y	N

Eyes

Cataracts	Y	N
Glaucoma	Y	N
Contact Lenses	Y	N

Neurologic

Migraines	Y	N

Cardiovascular

Irregular heart beat	Y	N
Chest Pain/Angina	Y	N
Pacemaker	Y	N
Palpitations	Y	N

Endocrine

Thyroid disease	Y	N
Osteoporosis	Y	N
Elevated cholesterol	Y	N

Psychological

Depression	Y	N
Anxiety	Y	N

Gastrointestinal

Heart burn/indigestion	Y	N
Abdominal pain	Y	N
Nausea/vomiting	Y	N
Diarrhea/constipation	Y	N

Cancer/Tumor

Location _____

Urologic

Prostate enlargement	Y	N
Urinary infections	Y	N

Respiratory

Croup	Y	N
Obstructive sleep apnea	Y	N

Skin

Eczema	Y	N
Hives	Y	N
Psoriasis	Y	N

Immunologic

Recurrent infections	Y	N	Where?_____
HIV	Y	N	
Blood transfusion	Y	N	
Immunizations Complete	Y	N	

Past Surgeries and dates, if known:

1. _____ Year _____
2. _____ Year _____
3. _____ Year _____
4. _____ Year _____
5. _____ Year _____
6. _____ Year _____

I. **Living Environment-Circle the following**

A. **Type of structure: Home Apartment Duplex Condo**
Location of Home: Country City Suburban
Proximal to: Factories Graineries Farm
Approximate age of home:_____ How long have you lived there?_____
Any smokers in residence? Yes No

B. **Do you have any of the following: Basement Crawl Space Slab**
Type of basement: Block Poured Finished Michigan cellar
Basement in winter: Dry Damp Basement in summer: Dry Damp
Basement musty or moldy: Yes No Basement leaks with rain: Yes No
Dehumidifier in basement: Yes No Symptoms worse in basement: Yes No

C. Type of Furnace: Gas Wood Oil Electric Coal
Location of furnace: Basement Crawl space 1st floor
Heating system: Forced air Radiator Steam Fireplace Space heater
Type of Filters: Disposable Permanent Electrostatic
Central air conditioning: Yes No Room air cleaner: Yes No
Humidifier on furnace: Yes No Portable humidifier location_____
Fireplace or wood burning stove: Yes No

D. Patient's Bedroom location: Basement 1st floor Upper floor
Bedroom Floor coverings: Carpet (shag) Carpet (short pile) Wood Tile Vinyl
Living Area Floor coverings: Carpet (shag) Carpet (short pile) Wood Tile Vinyl
Bed coverings: Feather comforter _____Yes _____No
Pillow(s): Polyester Foam Feather Cotton Pillow age____ Are pillows encased? Yes No
Mattress: Cotton innerspring Foam Water Feather Mattress age_____
Is Mattress encased? Yes No Is Box Spring encased? Yes No
Pets in bedroom: Yes No

E. Is there mold growing anywhere in the house:_____

F. Is there anything in your building, yard, or around your house that has not been mentioned that you think is significant in contributing to your problems?_____
_____
_____

II. **Inhalant History**

A. Dust: Dust exposure may cause either Nasal or Lung symptoms or both. With the following dust exposures, indicate which symptoms are worse by circling "N" to indicate Nasal, "L" to indicate Lung, "O" to indicate None, and "U" to indicate Unknown.

Dusty garage:	N	L	O	U	Breathing house dust:	N	L	O	U
Outdoor dust:	N	L	O	U	Dusting and/or vacuuming:	N	L	O	U
Feathers	N	L	O	U					

B. Molds/Pollens: Do your symptoms worsen after exposure to the following:

Hay:	Yes	No	Unknown	Raking Leaves:	Yes	No	Unknown
Barns:	Yes	No	Unknown	Cut dried grass/fresh cut grass:	Yes	No	Unknown
Damp Basements:	Yes	No	Unknown	Eating mushrooms:	Yes	No	Unknown
				Eating cheese:	Yes	No	Unknown

C. Danders: Please indicate the number of pets you own, their age and circle whether they are indoor or outdoor?

Cat #_____ Age_____ Outdoor/Indoor/Bedroom
Dog #_____ Age_____ Outdoor/Indoor/Bedroom
Parakeet #_____ Age_____ Outdoor/Indoor/Bedroom
Other #_____ Age_____ Outdoor/Indoor/Bedroom

What animals aggravate your symptoms?_____
Are you exposed to animals in your workplace? Yes_____ No_____
If so, what animals?_____

D. Miscellaneous: Which, if any of the following produce onset or an increase in symptoms?

Aerosols (sprays)	Nose	Chest	Both	Newspaper print	Nose	Chest	Both
Perfumes	Nose	Chest	Both	Tobacco smoke	Nose	Chest	Both
Strong chemical odors	Nose	Chest	Both	Detergent powders	Nose	Chest	Both
Diesel/gasoline fumes	Nose	Chest	Both				

E. Physical Agents: Do you have onset or increase of symptoms after exposure to the following?

Temperature change	Yes	No	Onset	Increase
Exercise	Yes	No	Onset	Increase
Drafts	Yes	No	Onset	Increase
Sunlight	Yes	No	Onset	Increase
Weather changes	Yes	No	Onset	Increase
Dampness/rain	Yes	No	Onset	Increase
Wine/beer	Yes	No	Onset	Increase
Barometric pressure change	Yes	No	Onset	Increase

III. **Do foods cause any symptoms?**

A. Name Food and Associated Symptoms

Food:_____ Symptoms:_____
Food:_____ Symptoms:_____
Food:_____ Symptoms:_____
(hives, rash, runny nose, nausea, vomiting, diarrhea, headache)

IV. **Social History**

A. Please indicate amount of use where applicable

Alcohol_____
Coffee/caffeine_____
Recreational drugs_____
Hobbies_____

Smoking Current_____ Past_____ Never____
Total number of years of smoking_____
If you were a smoker, date quit_____
Average packs per day_____
(cigarette, cigar, pipe)

V. Drugs

A. Have you ever had an adverse or allergic reaction to any medication?

Drug	Reaction	Date

VI. Insect Stings:

A. Have you ever had an unusual reaction from an insect sting? Yes No
Date:_____ Type of insect _____
Type of reaction:_____
_____

VII. Medications

A. List all current medications including strength and how often you take it:

	Med Name:	Strength (i.e. mg):	Frequency:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

VIII. Prescription Pharmacy

1. Local Pharmacy: _____
   Address: _____
   Phone #: _____
2. Mail Order Pharmacy: _____

IX. Have you received the Flu Shot this year?

No____ Yes_____ Date:_____