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

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Immune Deficiency 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:**_____

Have you had a Chest X-Ray, Cat Scan (CT) of the Chest or Sinus CT?

When:_____

Facility Location:_____

Do you now or have you had any problems related to the following? Circle Y (Yes) or N (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

Past Surgeries and dates, if known:

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

I. Have you had any of the following recurrent infections?

a. Sinus infections Y N
Explain:
_____

b. Bronchitis Y N
Explain:
_____

c. Pneumonia Y N
Explain:
_____

d. Urinary Tract infections Y N
Explain:
_____

e. Skin infections Y N
Explain:
_____

II. Have you been hospitalized for severe infection? Y N

If *YES*, **what infection**? **What facility**? **When were you hospitalized**?
_____
_____
_____

III. Have you been diagnosed with an autoimmune disease? For example Lupus, Rheumatoid arthritis or a Thyroid disease?

Explain**:**_____
_____
_____

IV. Have you been on IVIG (Intravenous Immunoglobulin)? Y N

Date started: _____ Date stopped: _____

V. Is there a family history of Immune Deficiency? Y N

VI. Do you have any gastrointestinal diseases? Y N

Explain**:**_____
_____
_____

VII. 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)

VIII. Drugs

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

Drug	**Reaction**	**Date**

IX. Immunizations:

A. Have you received the Pneumonia vaccine **Yes No**

Date:_____ **Facility:** _____

B. Have you received the Flu vaccine **Yes No**

Date: _____ **Facility:** _____

C. Other vaccines received

Vaccine: _____ **Date:** _____**Facility:**_____
Vaccine: _____ **Date:** _____**Facility:**_____

X. 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. _____

B. Prescription Pharmacy

1. Local Pharmacy: _____

   Address: _____

   Phone #: _____

2. Mail Order Pharmacy: _____