Michigan Avenue Internists
Brad Sabin MD – Asthma, Allergy, and Immunology
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Patient's Name: _____ Date of Birth: _____

*An accurate history is essential for proper diagnosis and treatment. Please fill out this information **before** your visit and bring it with you on the day of your visit, so that you can use your time with the doctor to your best advantage.*

Part One-Health History

1. Please describe the chief problem(s) that bring you to the allergist at this time?

_____
_____
_____
_____

2. If your problem is with the nose, ears or eyes, does it include:

[ ] sneezing	[ ] loss of smell	[ ] sinus infections needing antibiotic (____per year)	
[ ] watery nasal discharge	[ ] mouth breathing	[ ] ear infections needing antibiotic (_____per year)	
[ ] discolored discharge	[ ] snoring	[ ] loss of hearing	[ ] redness of eyes
[ ] post-nasal drip	[ ] sinus pressure	[ ] itching of ears	[ ] itching of eyes
[ ] nasal itch	[ ] nose bleeds	[ ] tearing	[ ] swelling of eyelids
[ ] nasal blockage	[ ] headache	[ ] _____	

3. If your problem is with the chest or breathing, does it include:

[ ] coughing	[ ] shortness of breath	[ ] decreased exercise capacity
[ ] wheezing you can hear	[ ] awakening at night	[ ] asthma attack(s) requiring emergency treatment
[ ] wheezing heard by MD	[ ] chest pain	[ ] asthma attack(s) requiring overnight hospitalization
[ ] tightness in chest	[ ] repeated episodes of bronchitis needing antibiotics (____ per year) ?	

4. If your problem is with the skin, does it include:

[ ] hives	[ ] dryness	[ ] itching
[ ] eczema	[ ] redness	

5. Duration and pattern:

[ ] symptoms have been present for _____ weeks / months / years		
[ ] spring	[ ] fall	[ ] year round at constant level
[ ] summer	[ ] winter	[ ] year round but worse during season(s) checked

6. Severity:

[ ] mild	[ ] interfere with sleep
[ ] moderate	[ ] interfere with physical exertion
[ ] severe	[ ] interfere with school or work

7. Please list all prescription and non-prescription medications (*including pills, inhalers, nose sprays, eye drops, and lotions*) that have been used to treat these symptoms:

[ ] _____	was it effective? _____	any side effects?_____
[ ] _____	was it effective? _____	any side effects?_____
[ ] _____	was it effective? _____	any side effects?_____
[ ] _____	was it effective? _____	any side effects?_____
[ ] _____	was it effective? _____	any side effects?_____
[ ] previous allergy testing? _____		when?_____
[ ] previous allergy injections? _____		when?_____

8. Please mark those exposures that you know make you feel worse:

[ ] exposure to house dust
[ ] cleaning house
[ ] cigarette smoke
[ ] exposure to basements
[ ] moldy smells
[ ] raking leaves
[ ] playing in leaves
[ ] exposure to compost
[ ] night time
[ ] cats
[ ] dogs
[ ] horses
[ ] birds
[ ] other animals_____
[ ] physical exertion
[ ] _____

[ ] change in barometric pressure
[ ] change in temperature
[ ] humidity
[ ] wind
[ ] cold air
[ ] heat
[ ] rain
[ ] perfumes
[ ] air pollution
[ ] morning
[ ] meals
[ ] lying down
[ ] menstrual cycle
[ ] cut grass
[ ] gardening
[ ] _____

[ ] work
[ ] home
[ ] school
[ ] other location_____

[ ] strong odors
[ ] plants
[ ] foods_____
[ ] chlorinated pool
[ ] cold viruses
[ ] alcohol
[ ] exercise
[ ] emotional stress
[ ] laughter

9. Do you have any of the following allergy problems? If you have already discussed them in the above section you may skip them here.

[ ] food allergy: list of foods: _____
[ ] medication allergies: list of medications: _____
[ ] allergy to dye injected for X-ray
[ ] allergy to latex or rubber
[ ] impressive swelling of lips, tongue, or throat
[ ] insect sting allergy *more than* large swelling at site of sting
[ ] hives

[ ] snoring, mouth breathing or sleep apnea
[ ] asthma
[ ] pneumonias (_____ in entire life)
[ ] eczema
[ ] contact skin allergy
[ ] allergic rhinitis

10. Please list any previous medical problems, including surgery:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

11. Please list all current medications and dosages:

_____ _____ _____ _____
_____ _____ _____ _____
_____ _____ _____ _____

12. If you are a woman, are you:

[ ] pregnant [ ] planning to become pregnant [ ] breast feeding

13. Have you had recent X-rays?

[ ] chest approximate date _____ result _____
[ ] chest CAT scan approximate date _____ result _____
[ ] sinus CAT scan approximate date _____ result _____

14. Please describe your social habits:

[ ] cigarettes _____ pack per day [ ] former smoker, quit _____
[ ] alcohol _____ drinks per _____ [ ] former drinker, stopped _____
[ ] "recreational" drugs_____
[ ] travel out of US _____

15. Please list allergies and major non-allergic illnesses in family members:

[ ] patient's father _____
[ ] patient's mother _____
[ ] patient's brother(s) _____
[ ] patient's sisters(s) _____
[ ] patient's children _____
[ ] patient's grandparents _____
[ ] patient's cousins, aunts, uncles _____

Part Two-Environmental History

Type of home
- [ ] private house
- [ ] condominium
- [ ] apartment in apt. building
- [ ] apartment in house
- [ ] dormitory

Basement
- [ ] finished
- [ ] unfinished
- [ ] none
- [ ] damp and musty
- [ ] dirt cellar

Heating
- [ ] baseboard hot water
- [ ] radiator hot water
- [ ] forced hot air
- [ ] electric baseboard
- [ ] wood stove

Humidification
- [ ] none
- [ ] de-humidifier
- [ ] room humidifier
- [ ] central humidifier

Cooling
- [ ] none
- [ ] window
- [ ] central

Bedroom floor
- [ ] wall-to-wall carpet
- [ ] hardwood floor
- [ ] hardwood floor with small area rug
- [ ] linoleum
- [ ] tile
- [ ] hardwood floor with large area rug

Mattress and Pillow
- [ ] encased in dust-proof cover

Mold Damage in your house or place of work
[ ] none [ ] yes where?_____

Cats
[ ] none [ ] yes
number: _____ for how many years?_____ go in the bedroom: [ ] yes [ ] no

Dogs
[ ] none [ ] yes
number: _____ for how many years?_____ go in the bedroom: [ ] yes [ ] no

Other animals
- [ ] none
- [ ] rabbit
- [ ] gerbil
- [ ] cattle
- [ ] guinea pig
- [ ] mouse
- [ ] ferret
- [ ] hamster
- [ ] horse
- [ ] bird
- [ ] _____

Pests
- [ ] cockroaches
- [ ] mice

Second hand cigarette exposure
- [ ] none
- [ ] yes: describe _____

Hobbies
[ ] describe _____

Occupation _____

Describe any exposures at work that worsen your symptoms _____

General Review of Systems: Please mark if you are currently experiencing any symptoms listed below.
General: ____chills ____weight change ____ fatigue ____loss of appetite
Eyes: _____ blurred vision
Cardiovascular: ____chest pain ____ palpitations _____leg swelling
Gastrointestinal: ____Abdominal pain ____nausea _____vomiting _____heartburn
Neurological: ____headaches ____seizures ____dizziness _____weakness ____numbness
Psychiatric: _____depression ____anxiety ____panic
Endocrine: _____cold/heat intolerance
Heme/Onc: _____easy bruising _____anemia
Genitourinary: _____frequent urination ____ pain on urination ____blood in urine
Musculoskeletal: ___joint pain ____joint swelling ____back pain

Thank you for your cooperation in completing this form.