

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:

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> sneezing | <input type="checkbox"/> loss of smell | <input type="checkbox"/> sinus infections needing antibiotic (____ per year) | |
| <input type="checkbox"/> watery nasal discharge | <input type="checkbox"/> mouth breathing | <input type="checkbox"/> ear infections needing antibiotic (____ per year) | |
| <input type="checkbox"/> discolored discharge | <input type="checkbox"/> snoring | <input type="checkbox"/> loss of hearing | <input type="checkbox"/> redness of eyes |
| <input type="checkbox"/> post-nasal drip | <input type="checkbox"/> sinus pressure | <input type="checkbox"/> itching of ears | <input type="checkbox"/> itching of eyes |
| <input type="checkbox"/> nasal itch | <input type="checkbox"/> nose bleeds | <input type="checkbox"/> tearing | <input type="checkbox"/> swelling of eyelids |
| <input type="checkbox"/> nasal blockage | <input type="checkbox"/> headache | <input type="checkbox"/> _____ | |

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

- | | | |
|--|--|---|
| <input type="checkbox"/> coughing | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> decreased exercise capacity |
| <input type="checkbox"/> wheezing you can hear | <input type="checkbox"/> awakening at night | <input type="checkbox"/> asthma attack(s) requiring emergency treatment |
| <input type="checkbox"/> wheezing heard by MD | <input type="checkbox"/> chest pain | <input type="checkbox"/> asthma attack(s) requiring overnight hospitalization |
| <input type="checkbox"/> tightness in chest | <input type="checkbox"/> repeated episodes of bronchitis needing antibiotics (____ per year) ? | |

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

- | | | |
|---------------------------------|----------------------------------|----------------------------------|
| <input type="checkbox"/> hives | <input type="checkbox"/> dryness | <input type="checkbox"/> itching |
| <input type="checkbox"/> eczema | <input type="checkbox"/> redness | |

5. Duration and pattern:

- | | | |
|--|---------------------------------|--|
| <input type="checkbox"/> symptoms have been present for _____ weeks / months / years | | |
| <input type="checkbox"/> spring | <input type="checkbox"/> fall | <input type="checkbox"/> year round at constant level |
| <input type="checkbox"/> summer | <input type="checkbox"/> winter | <input type="checkbox"/> year round but worse during season(s) checked |

6. Severity:

- | | |
|-----------------------------------|---|
| <input type="checkbox"/> mild | <input type="checkbox"/> interfere with sleep |
| <input type="checkbox"/> moderate | <input type="checkbox"/> interfere with physical exertion |
| <input type="checkbox"/> severe | <input type="checkbox"/> 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:

- | | | |
|---|-------------------------|-------------------------|
| <input type="checkbox"/> _____ | was it effective? _____ | any side effects? _____ |
| <input type="checkbox"/> _____ | was it effective? _____ | any side effects? _____ |
| <input type="checkbox"/> _____ | was it effective? _____ | any side effects? _____ |
| <input type="checkbox"/> _____ | was it effective? _____ | any side effects? _____ |
| <input type="checkbox"/> _____ | was it effective? _____ | any side effects? _____ |
| <input type="checkbox"/> previous allergy testing? | _____ | when? _____ |
| <input type="checkbox"/> previous allergy injections? | _____ | when? _____ |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> exposure to house dust | <input type="checkbox"/> change in barometric pressure | <input type="checkbox"/> work |
| <input type="checkbox"/> cleaning house | <input type="checkbox"/> change in temperature | <input type="checkbox"/> home |
| <input type="checkbox"/> cigarette smoke | <input type="checkbox"/> humidity | <input type="checkbox"/> school |
| <input type="checkbox"/> exposure to basements | <input type="checkbox"/> wind | <input type="checkbox"/> other location _____ |
| <input type="checkbox"/> moldy smells | <input type="checkbox"/> cold air | |
| <input type="checkbox"/> raking leaves | <input type="checkbox"/> heat | |
| <input type="checkbox"/> playing in leaves | <input type="checkbox"/> rain | <input type="checkbox"/> strong odors |
| <input type="checkbox"/> exposure to compost | <input type="checkbox"/> perfumes | <input type="checkbox"/> plants |
| <input type="checkbox"/> night time | <input type="checkbox"/> air pollution | <input type="checkbox"/> foods _____ |
| <input type="checkbox"/> cats | <input type="checkbox"/> morning | <input type="checkbox"/> chlorinated pool |
| <input type="checkbox"/> dogs | <input type="checkbox"/> meals | <input type="checkbox"/> cold viruses |
| <input type="checkbox"/> horses | <input type="checkbox"/> lying down | <input type="checkbox"/> alcohol |
| <input type="checkbox"/> birds | <input type="checkbox"/> menstrual cycle | <input type="checkbox"/> exercise |
| <input type="checkbox"/> other animals _____ | <input type="checkbox"/> cut grass | <input type="checkbox"/> emotional stress |
| <input type="checkbox"/> physical exertion | <input type="checkbox"/> gardening | <input type="checkbox"/> laughter |
| <input type="checkbox"/> _____ | <input type="checkbox"/> _____ | |

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.

- | | |
|--|--|
| <input type="checkbox"/> food allergy: list of foods: _____ | <input type="checkbox"/> snoring, mouth breathing or sleep apnea |
| <input type="checkbox"/> medication allergies: list of medications: _____ | <input type="checkbox"/> asthma |
| <input type="checkbox"/> allergy to dye injected for X-ray | <input type="checkbox"/> pneumonias (_____ in entire life) |
| <input type="checkbox"/> allergy to latex or rubber | <input type="checkbox"/> eczema |
| <input type="checkbox"/> impressive swelling of lips, tongue, or throat | <input type="checkbox"/> contact skin allergy |
| <input type="checkbox"/> insect sting allergy <i>more than</i> large swelling at site of sting | <input type="checkbox"/> allergic rhinitis |
| <input type="checkbox"/> hives | |

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?

- | | | |
|---|------------------------|--------------|
| <input type="checkbox"/> chest | approximate date _____ | result _____ |
| <input type="checkbox"/> chest CAT scan | approximate date _____ | result _____ |
| <input type="checkbox"/> 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

Humidification

- none
- de-humidifier
- room humidifier
- central humidifier

Basement

- finished
- unfinished
- none
- damp and musty
- dirt cellar

Cooling

- none
- window
- central

Heating

- baseboard hot water
- radiator hot water
- forced hot air
- electric baseboard
- wood stove

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.