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

3. If your problem is with the chest or breathing, does it include:
- coughing
- wheezing you can hear
- wheezing heard by MD
- tightness in chest
- shortness of breath
- awakening at night
- chest pain
- repeated episodes of bronchitis needing antibiotics (____per year) ?
- decreased exercise capacity
- asthma attack(s) requiring emergency treatment
- asthma attack(s) requiring overnight hospitalization

4. If your problem is with the skin, does it include:
- hives
- eczema
- dryness
- redness
- itching

5. Duration and pattern:
- symptoms have been present for _____ weeks / months / years
- spring
- summer
- fall
- winter
- year round at constant level
- year round but worse during season(s) checked

6. Severity:
- mild
- moderate
- severe
- interfere with sleep
- interfere with physical exertion
- 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
- change in barometric pressure
- change in temperature
- humidity
- wind
- cold air
- work
- home
- school
- other location___________

- raking leaves
- playing in leaves
- exposure to compos
- night time
- cats
- dogs
- horses
- birds
- other animals__________
- physical exertion
- _____________________

- heat
- rain
- perfumes
- air pollution
- morning
- meals
- lying down
- menstrual cycle
- cut grass
- gardening
- _______________________

- 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
    - snoring, mouth breathing or sleep apnea
    - asthma
    - pneumonias (____ in entire life)
    - insect sting allergy *more than* large swelling at site of sting
    - eczema
    - contact skin allergy
    - allergic rhinitis
    - 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?
    - 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
    - alcohol _____drinks per ______
    - “recreational” drugs__________________
    - travel out of US ____
    - former smoker, quit ___________
    - former drinker, stopped_________

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
- guinea pig
- horse
- rabbit
- mouse
- bird
- gerbil
- ferret
- _____________
- cattle
- hamster

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.