

Appointment Date: \_\_\_\_\_

Name: \_\_\_\_\_

Consult requested by: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: \_\_\_\_\_

Primary doctor: \_\_\_\_\_

**PATIENT PLEASE COMPLETE THIS SIDE** (blue/black ink only)

The Reason I Am Here Is: \_\_\_\_\_

Please Check What Best Describes Your Symptoms:

		Major Problem	Less of a Problem	Not a Problem
<b>NOSE</b>	Stuffy nose	_____	_____	_____
	Runny nose	_____	_____	_____
	Sneezing	_____	_____	_____
	Itching	_____	_____	_____
	Drainage down throat	_____	_____	_____
	Facial pressure	_____	_____	_____
	Sore throat	_____	_____	_____
	Headaches	_____	_____	_____
	Snoring	_____	_____	_____
	Loss of sense of smell	_____	_____	_____
<b>EYES</b>	Itchy	_____	_____	_____
	Watery	_____	_____	_____
	Swelling	_____	_____	_____
	Red	_____	_____	_____
	Pain	_____	_____	_____
<b>EARS</b>	Ear infections	_____	_____	_____
	Itchy	_____	_____	_____
	Popping/Cracking	_____	_____	_____
	Hearing loss	_____	_____	_____
	Earache	_____	_____	_____
<b>CHEST</b>	Chest tight or heavy	_____	_____	_____
	Wheezing	_____	_____	_____
	Coughing	_____	_____	_____
	Phlegm	_____	_____	_____
	Symptoms at night	_____	_____	_____
<b>GI</b>	Suspected food reaction	_____	_____	_____
	Vomiting	_____	_____	_____
	Acid reflux	_____	_____	_____
	Heartburn/Indigestion	_____	_____	_____
	Abdominal pain	_____	_____	_____
<b>SKIN</b>	Diarrhea	_____	_____	_____
	Eczema	_____	_____	_____
	Hives	_____	_____	_____
	Itch	_____	_____	_____
<b>OTHER</b>	Other	_____	_____	_____
	Bee sting reaction	_____	_____	_____

**STAFF NOTES**

History given by: \_\_\_\_\_

Relationship if not patient: \_\_\_\_\_

Meds tried in past: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**Symptoms Are Triggered by: (Circle all that apply)**

SEASON:            Spring    Summer    Fall    Winter

LOCATION:            Work    Home    Cabin    Relatives    Other \_\_\_\_\_

TIME OF DAY:      Morning    Evening    Night

Cold air    Dust    Smoke    Stress    Viral cold    Food    Pollen  
Dampness    Fumes    Exercise    School    Grass    Pets  
Weather changes    Other \_\_\_\_\_

Name: \_\_\_\_\_

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**STAFF NOTES**

**Past Allergy History:**

Previous allergy testing?  No  Yes  
If yes, where? \_\_\_\_\_

Previous allergy shots?  No  Yes When? \_\_\_\_\_

Did allergy shots help?  No  Yes

**Past Medical History:**

MEDICAL PROBLEMS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HOSPITALIZATIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

SURGERIES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Check all that apply to you:

- High blood pressure
- Heart disease
- Diabetes
- Kidney disease
- Pneumonia
- Acid reflux/Heartburn
- Sinus infections
- Thyroid disease
- Liver disease
- Recurrent infections
- Adenoids removed
- Tonsils removed
- Sinus/nasal surgery

**Drug allergies:**

<u>NAME OF DRUG</u>	<u>SYMPTOMS</u>
_____ CAUSED _____	
_____ CAUSED _____	
_____ CAUSED _____	

**Current List of All Medicines You are Taking** (include nutritional supplements, natural remedies, & over the counter):

**Any Known Latex Allergy?**  No  Yes

If Yes, Describe:

**Birth History and Childhood History** (If under 12 yrs):

Prolonged Hospitalization as Newborn:  Yes  No

Immunizations up to date?  Yes  No

Growth & Development?  Seems normal  Have concerns

**Family Medical History** (Check if applicable):

	<u>Allergies</u> <u>Or Sinus</u>	<u>Asthma or</u> <u>Bronchitis</u>	<u>Cystic</u> <u>Fibrosis</u>	<u>TB</u>	<u>Other</u>
Father	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Children	_____	_____	_____	_____	_____
Grandparent(s)	_____	_____	_____	_____	_____
Aunt/Uncle(s)	_____	_____	_____	_____	_____

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STAFF NOTES

**Social History:**

MARITAL STATUS:

\_\_\_ Single \_\_\_ Married \_\_\_ Divorced \_\_\_ Separated  
\_\_\_ Domestic partner

CURRENT OCCUPATION: \_\_\_\_\_

CHILD: School \_\_\_\_\_ Daycare \_\_\_\_\_

LEVEL OF EDUCATION: \_\_\_\_\_

ALCOHOL/DRUG USE: \_\_\_\_\_

**Do you smoke cigarettes?:** \_\_\_ No \_\_\_ Yes

- \_\_\_ Never smoked
- \_\_\_ Smoked previously, but quit \_\_\_ years ago
- \_\_\_ Smoked previously, (\_\_\_ packs per day for \_\_\_ years)
- \_\_\_ Smoke now, (\_\_\_ packs per day for \_\_\_ years)
- \_\_\_ Subject to second hand smoke
  - \_\_\_ At home (number of smokers: \_\_\_)
  - \_\_\_ At work

**Environmental History: (Check all that apply)**

HOME CONSTRUCTION: \_\_\_ Apartment \_\_\_ Mobile Home  
\_\_\_ House \_\_\_ Other

HOME LOCATION: \_\_\_ City \_\_\_ Suburbs \_\_\_ Farm \_\_\_ Country

AGE OF HOME: \_\_\_ Years

HEAT: \_\_\_ Forced Air \_\_\_ Hot Water \_\_\_ Space Heater \_\_\_ Wood  
\_\_\_ Kerosene \_\_\_ Gas \_\_\_ Electric

AIR CONDITIONING: \_\_\_ Central \_\_\_ Window \_\_\_ None

HUMIDIFIER: \_\_\_ Yes \_\_\_ No

YOUR BEDROOM FLOOR: \_\_\_ Wood \_\_\_ Carpet \_\_\_ Linoleum \_\_\_ Other

YOUR BEDROOM LOCATION: \_\_\_ Basement \_\_\_ First Floor \_\_\_ Second Floor

BASEMENT: \_\_\_ None \_\_\_ Damp \_\_\_ Dry \_\_\_ Flooded in past \_\_\_ Visible mold

**PETS:**

\_\_\_ Dogs (Years owned \_\_\_ Number \_\_\_) \_\_\_ Inside \_\_\_ Outside \_\_\_ In bedroom  
\_\_\_ Cats (Years owned \_\_\_ Number \_\_\_) \_\_\_ Inside \_\_\_ Outside \_\_\_ In bedroom  
\_\_\_ Other Animals (Please List): \_\_\_\_\_

ANY MOLD PROBLEMS AT HOME, SCHOOL, OR WORK? \_\_\_ No \_\_\_ Yes

**Review of systems (Check all that apply):**

- |                                    |                              |
|------------------------------------|------------------------------|
| ___ Fever                          | ___ Heart problems           |
| ___ Weight loss or gain            | ___ High blood pressure      |
| ___ Blood count problems           | ___ Chest pain               |
| ___ Fatigue                        | ___ Poor circulation         |
| ___ Headaches                      | ___ Stomach upset            |
| ___ Seizures                       | ___ Stomach ulcer            |
| ___ Dizziness                      | ___ Irritable bowel          |
| ___ Nervous problems               | ___ Diarrhea                 |
| ___ Depressed mood                 | ___ Constipation             |
| ___ Muscle weakness                | ___ Joint swelling or pain   |
| ___ Cataracts                      | ___ Glaucoma                 |
| ___ Wear corrective lenses         | ___ Urinary bladder problems |
| ___ Kidney problems                | ___ Sore throat              |
| ___ Pregnancy or pregnancy planned | ___ Difficulty swallowing    |
| ___ Diabetes                       | ___ Throat infections        |
| ___ Thyroid disorder               |                              |

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**PHYSICIAN NOTES:**

**Physical Examination**

NML      ABNL      Ht.      in. Wt.      lbs. BP       
 \_\_\_\_\_  
 \_\_\_\_\_ Con: P      R      T       
 \_\_\_\_\_ Gen: Develop      Small for age      Overweight       
 \_\_\_\_\_ Eyes: Injected      Edema      Icterus      Periob      Lid      Shiners       
 \_\_\_\_\_ Sinus: Tender      Max      Front      Ethmoid       
 \_\_\_\_\_ Ears: Dull      Red      Retrac      Fluid      Cer      Tubes      Sclerosis       
 \_\_\_\_\_ Nose: Edema      Pallor      Eryth      Disch      Polyp      Septum       
 \_\_\_\_\_ Mouth/Throat: Eryth      Ulcer      Drainage      Tonsils      Exudate       
 \_\_\_\_\_ Dental: Teeth      Gums       
 \_\_\_\_\_ Neck: Masses      Laryngeal wheeze      I      E       
 \_\_\_\_\_ Thyroid: Enlarged      Tender      Masses       
 \_\_\_\_\_ Chest: Clear      Rhonchi      Wheeze      I      E      Rales       
 \_\_\_\_\_ Resp effort: Retrac      Tachypnes      Acc Musc      Prolong Expir       
 \_\_\_\_\_ CV: Rate      Rhythm      Murmurs      Gallops       
 \_\_\_\_\_ Peripheral: Pulses      Edema      Varicosities       
 \_\_\_\_\_ GI: Mass      Tenderness      Liver      Spleen       
 \_\_\_\_\_ Lymph: Neck      Axillae      Groin      Cervical      Supraclav       
 \_\_\_\_\_ Extrem: Clubbing      Cyanosis      Edema       
 \_\_\_\_\_ Skin: Eryth      Excor      Hives      Scale      Angio       
 \_\_\_\_\_ Neuro: CN2-12      DTR      Sens      CBLL       
 \_\_\_\_\_ Orient: Time      Place      Person       
 \_\_\_\_\_ Mood:      Dep      Anxious      Agitated     

**DATA PERFORMED & REVIEWED:**

\_\_\_\_\_ Sinus x-ray \_\_\_\_\_ CXR \_\_\_\_\_ Labs \_\_\_\_\_ PFT \_\_\_\_\_ Skin Test \_\_\_\_\_ Shot Records \_\_\_\_\_ Old Record

**LAB DATA:**

Conference with Patient/Parent/Other:

**IMPRESSION:**

**PLAN:**

**(CHECK ALL THAT APPLY)**

Inhaler educ/demo \_\_\_\_\_ Asthma action plan \_\_\_\_\_  
 Use of spacer device \_\_\_\_\_ Nasal spray educ/dem \_\_\_\_\_  
 Epi-Pen educ/demo \_\_\_\_\_ Acid reflux precautions \_\_\_\_\_  
 Allergen avoidance \_\_\_\_\_ Allergy/Asthma handout \_\_\_\_\_

More than 1/2 of this \_\_\_\_\_ minute face-to-face visit was spent discussing above.

Follow Up: \_\_\_\_\_

Physician Signature: \_\_\_\_\_