Provo Allergy & Asthma Clinic

Patient Health History

***In order for us to obtain a complete medical history, it is important for you to complete this form in its entirety.**

Patient name: _____ Date of birth: _____ **Today's Date**: _____

What <u>CONDITION</u> are you being seen in our office for?
____ Seasonal Allergies ____ Insect/Bee stings ____ Mold allergy _____Hives _____Asthma ____Pet Allergies
____ Food Allergies Other:_____

Please circle all symptoms that apply:

Nasal congestion	**Nasal itch**	**Sneezing**	**Ear Pressure**	**Plugged ears**	**Itchy Eyes**
Watery eyes	**Postnasal drip**	**Cough**	**Chest tightness**	**Wheezing**	**Shortness of breath**
Eczema	**Hives**	**Itching**	**Nasal polyps**	**Headaches**	**Sinus infections**

Please circle all things that seem to cause symptoms:

Spring pollen	**Fall pollen**	**Dogs**	**Cats**	**Feathers**	**Mold**	**Home**
Indoors	**Outdoors**	**Strong odors**	**Workplace**	**Heat**	**Cold**	**Smoke**
Weather changes	**Wind**	**Exercise**	**Rain**	**Pollution**	**Viral illness**	

PAST ALLERGY HISTORY
Previous allergy testing Yes___ No___
If yes, where and when_____
Previous allergy shots Yes___ No___ if yes, how long were they taken? _____

ENVIRONMENTAL HISTORY (Please circle all things that apply)

Residence:
House
Apartment
Mobile home
Other_____

Air Conditioning:
Central air
Window unit
Swamp cooler
None

Heating system:
Gas/forced air Propane
Wood/fireplace
Electric
Radiant

Region:
Rural
Urban/City
Farm/ranch

Bedding:
Foam
Feathers
Polyester
Other: _____

Pets:
Dog (s) How many?_____ Indoors_____ Outdoors_____ Sleeps in bedroom_____
Cat (s) How many**?**_____ Indoors_____ Outdoors_____ Sleeps in bedroom_____
Other animals (please list)_____

SOCIAL HISTORY
Current occupation_____ If patient is a child does he/she attend daycare? Yes No
Hobbies:_____ Exercise: (type)_____
Number of days missed from school/work in the past year due to your symptoms? _____

Do you currently smoke? Yes___ No___ If yes, how long? _____ #packs per day_____
Are you a former smoker? Yes___ No___ If yes, how long?_____ #packs per day_____
When did you quit? _____ Are you exposed to second hand smoke? Yes___ No ___Where? _____
Recreational Drug use? Yes____ No_____ If yes how frequent and type?_____

PATIENT HEALTH HISTORY CONTINUED

Medication:	Dose/frequency	Medication:	Dose/frequency

IMMUNIZATION HISTORY
Are your routine immunizations up to date? ____Yes ____No
Date of last influenza vaccine. _____ Date of last Pneumonia vaccine_____

FAMILY HISTORY-Please indicate if there is a family history of any of the following:

	ALLERGIES	ASTHMA	ECZEMA	HIVES	SINUSITIS
Mother					
Father					
Grandparent(s)					
Brother(s)					
Sister(s)					

Review of Systems

Please circle any symptoms you have now or have ongoing problems with.

Category	Issue	No Issue
General	Recent weight change Fever Chills Night sweats Weakness Fatigue	☐
Eyes	Pain Redness Watering Contact lenses/glasses Glaucoma Cataracts	☐
Ears/Nose/throat	Hearing loss dizziness Ringing in ears Sores in mouth Dental issues	☐
Respiratory	Cough Shortness of breath Wheezing COPD Respiratory infections	☐
Cardiovascular	High blood pressure Chest pain Palpitations Heart murmur Swelling of feet/ankles	☐
Endocrine	Heat/cold intolerance Diabetes Thyroid disorder	☐
Gastrointestinal	Abdominal pain Constipation Diarrhea Nausea Reflux/heartburn Vomiting	☐
Musculoskeletal	Joint Pain Muscle pain Muscle weakness Muscle cramps Limitation of motion	☐
Genitourinary	Chronic urinary infections Incontinence Kidney stones	☐
Skin	Dryness Blistering Itching Hives Facial swelling	☐
Neurological	Fainting Seizures Numbness/tingling Memory loss	☐
Psychiatric	Depression Anxiety Insomnia ADD/ADHD	☐

MEDICATION ALLERGIES: (please list medication and type of reaction)

Patient (or Guardian) Signature_____

Physician Signature_____