Patient Name: _____ Patient DOB: ____/____/_____ Date: ____/____/_____

PATIENT CLINICAL HISTORY

Asthma: Complete this section if you have respiratory symptoms or a diagnosis of asthma.
If this section does not apply, check the following box: ☐ N/A

Check all applicable symptoms:
☐ Cough ☐ Wheeze ☐ Chest Tightness ☐ Shortness of Breath

How often do symptoms occur?

☐ Daily ☐ Weekly ☐ Monthly ☐ When I am sick ☐ Rare

Do symptoms worsen at night? ☐ YES ☐ NO

Do symptoms worsen upon awakening? ☐ YES ☐ NO

Are symptoms worse when lying flat? ☐ YES ☐ NO

Are symptoms worse with exercising or exertion? ☐ YES ☐ NO

Do you use a rescue inhaler or albuterol inhaler? ☐ YES ☐ NO

If yes, how often? ☐ Daily ☐ Weekly ☐ Monthly ☐ When I am sick ☐ Rare

If you use a rescue inhaler weekly or more, do you need it consistently 2 times in a week or more? ☐ YES ☐ NO

Do you have regular breathing tests either at your provider's office or at home (peak flows)? ☐ YES ☐ NO

If yes, when was your last peak flow and what was the value?

_____

Family History: Place **X** under self or **age** of family members with any of the following medical conditions:

Condition	Self	Father	Mother	Brothers	Sisters	Children
Migraine						
Hay Fever						
Hives						
Eczema						
Asthma						

Additional Information: Please elaborate on family history of environmental and/or food allergies.
If this section does not apply, check the following box: ☐ N/A

Input any of the following which are applicable below (one per line): Father, Mother, Brothers, Sisters, Children	Next to applicable family member input specific allergy (environmental or food) and provide any additional details

Patient Name: _____ Patient DOB: ____/____/_____ Date: ____/____/_____

ENVIRONMENTAL ALLERGY HISTORY

If this section was completed during prior visit, check the following box: ☐ Previously completed
If this section does not apply, check the following box: ☐ N/A

When did allergies begin? (Year) _____

What symptoms do you experience? (check all that apply)

☐ Runny Nose	☐ Stuffy Nose	☐ Itchy Nose/Mouth/Throat/Ears	☐ Itchy Eyes
☐ Watery Eyes	☐ Sneezing	☐ Post Nasal Drainage	☐ Sinus Pain/Pressure
☐ Ear Pain/Pressure	☐ Itchy Skin	☐ Rash	

When do symptoms occur? (check all that apply)

☐ All months

☐ January	☐ April	☐ July	☐ October
☐ February	☐ May	☐ August	☐ November
☐ March	☐ June	☐ September	☐ December

When are symptoms worse?

☐ Morning	☐ Afternoon	☐ Evening	☐ Night
☐ At home	☐ At work	☐ At school	☐ Other location: _____
Symptoms are:	☐ Constant	☐ Occasional	☐ Rare

Symptoms interfere with activities:

☐ Not at all ☐ Mildly ☐ Moderately ☐ All the time

ENVIRONMENT

☐ Soap	☐ Powder	☐ Perfumes	☐ Cosmetics	☐ Paint Fumes
☐ Barns/Hay	☐ Mowing Lawns/Cut Grass	☐ Insecticides	☐ Dust	☐ Rugs/rug pads
☐ Furniture	☐ Feather pillows	☐ Stuffed toys	☐ Air-conditioning	☐ Weather change
☐ Dry weather	☐ Wet weather	☐ Hot day	☐ Cold day	☐ Damp areas
☐ Cut flowers	☐ House plants	☐ Christmas trees		

☐ Other: (list all) _____

Indoors, explain: _____

Outdoors, explain: _____

PETS

☐ Horse ☐ Cat: Indoor/Outdoor ☐ Dog: Indoor / Outdoor

☐ Other: (list) _____

Have you been diagnosed with eczema or atopic dermatitis? ☐ YES ☐ NO

If yes, what do you use if anything to control it: _____

Have you ever been allergy tested? ☐ YES ☐ NO

If yes, when was the last time? _____

Have you ever been placed on immunotherapy (allergy shots, allergy drops or specific prescription of allergy tablets)? ☐ YES ☐ NO

If yes, what type were you on? _____

How long were you on immunotherapy? _____

Did immunotherapy help? _____

Were there any issues while on immunotherapy? ☐ YES ☐ NO

If yes, please explain: _____

Any adverse effects while on any medication? ☐ YES ☐ NO

If yes, what medication(s) and what occurred: _____

Do you utilize a HEPA air purifier, HEPA HVAC air filter or other HEPA filtration device in your current residence? ☐ YES ☐ NO

Patient Name: _____ Patient DOB: ____/____/_____ Date: ____/____/_____

FOOD ALLERGY HISTORY

If this section was completed during prior visit, check the following box: ☐ Previously completed
If this section does not apply, check the following box: ☐ N/A

Have you ever experienced a reaction to food(s)? ☐ YES ☐ NO
If yes, when was your last reaction? _____ ☐ N/A
Please describe fully the reaction that occurred (if unable to be specific on food or reaction provide any detail you can, such a "after breakfast, or lunch, or dinner)_____
_____
How soon after consuming the food(s) did the reaction occur? _____ ☐ N/A
Has this occurred more than one time? ☐ YES ☐ NO ☐ N/A
If yes, does this occur each time you are exposed to the food(s)? ☐ YES ☐ NO ☐ N/A
How long did the reaction last? _____ ☐ N/A
Did you need to take any medication or seek medical help? ☐ YES ☐ NO ☐ N/A
If yes, please describe: _____
_____ ☐ N/A
Do you currently avoid the food(s)? ☐ YES ☐ NO ☐ N/A

Have you experienced a reaction to food specifically after exercising? ☐ YES ☐ NO
What food triggered the reaction (coupled with exercise)? _____ ☐ N/A
Can you tolerate the food if eaten without exercising? ☐ YES ☐ NO ☐ N/A
Have you experienced a reaction to food specifically when also consuming alcohol? ☐ YES ☐ NO
What food triggered the reaction (coupled with alcohol)? _____ ☐ N/A
Can you tolerate the food if eaten without consuming alcohol? ☐ YES ☐ NO ☐ N/A
Have you experienced a reaction to food specifically when also taking a NSAIDs (ie Ibuprofen, aspirin)? ☐ YES ☐ NO
What food triggered the reaction (coupled with NSAID use)? _____ ☐ N/A
Can you tolerate the food if eaten without taking an NSAID? ☐ YES ☐ NO ☐ N/A

Have you ever been tested for food allergy? ☐ YES ☐ NO
If yes, when? _____
Were you tested on your skin or via a blood test? _____
Was the test positive? ☐ YES ☐ NO
If yes, what did you test positive to? _____

Do you experience symptoms when exposed to the food(s) you tested positive to? ☐ YES ☐ NO
If yes, what symptoms? _____

Do you avoid the food(s) you tested positive to? ☐ YES ☐ NO

Do you have a known food intolerance? ☐ YES ☐ NO ☐ N/A If yes, describe_____

For Provider Use Only:

ADDITIONAL NOTES:

_____ _____ ____/____/_____
Patient/Guardian Printed Name Patient/Guardian Signature Date

_____ _____ ____/____/_____
Provider Printed Name Provider Signature Date