ALLERGY & ASTHMA CARE OF THE PALM BEACHES

PATIENT EVALUATION

Name _____ Date _____

The main problem for coming here is: _____

PHYSICIAN'S NOTES

*PLEASE COMPLETE **EVERY** BOX "YES" OR "NO"*

NOSE

PHYSICIAN'S NOTES

Do your problems include?

- Runny Nose? ☐ Yes ☐ No
- Sneezing? ☐ Yes ☐ No
- Itchy Nose? ☐ Yes ☐ No
- Nasal Congestion? ☐ Yes ☐ No

If ***YES,*** is there any pattern to this (for example time of day or year; exposure to dust, animals or smoke; other factors such as heat, cold, travel, etc.) –OR- ***NO*** pattern at all (for example, constant, "comes and goes" with ***NO*** pattern noted)?

Do you use, or have you ever used a nose spray? ☐ Yes ☐ No

If YES: ☐ Prescription nose spray:

- Name _____
- Last used _____
- Did it help? ☐ Yes ☐ No

☐ Over-the-Counter nose spray:

- Name _____
- Last used _____
- Did it help? ☐ Yes ☐ No

Do you use, or have you ever used antihistamines and/or decongestants for nasal symptoms? ☐ Yes ☐ No

If YES: ☐ Prescription antihistamine and/or decongestant

- Name _____
- Last used _____
- Do they help? ☐ Yes ☐ No

☐ Over-the-Counter antihistamine and/or decongestant

- Name _____
- Last used _____
- Do they help? ☐ Yes ☐ No

Do antihistamines make you sleepy? ☐ Yes ☐ No

EYES

Do your problems include: **PHYSICIAN'S NOTES**

- Red eyes? ☐ Yes ☐ No
- Watery eyes? ☐ Yes ☐ No
- Itchy eyes? ☐ Yes ☐ No
- Puffy eyes? ☐ Yes ☐ No

If ***YES,*** is there any pattern to this (for example time of day or year; exposure to dust, animals or smoke; other factors such as heat, cold, travel, etc.) –OR- ***NO*** pattern at all (for example, constant, "comes and goes" with ***NO*** pattern noted)?

Do you use, or have you ever used, eye drops? ☐ Yes ☐ No

If ***YES***: Name _____

Last used _____

Did it help? ☐ Yes ☐ No

EARS

Have you had frequent ear infections? ☐ Yes ☐ No

Do you have any ear complaints? ☐ Yes ☐ No

SKIN

Have you ever had skin allergies? ☐ Yes ☐ No

If ***YES***: ☐ Hives ☐ Eczema

SINUS

Have you ever been diagnosed as having sinusitis (a sinus infection)? ☐ Yes ☐ No **PHYSICIAN'S NOTES**

Have you ever had a sinus CT Scan? ☐ Yes ☐ No

If ***YES***, were the results normal? ☐ Yes ☐ No

Have you ever had a sinus x-ray? ☐ Yes ☐ No

If ***YES***, were the results normal? ☐ Yes ☐ No

Do you have:

- Postnasal drip? ☐ Yes ☐ No
- Sinus Pressure? ☐ Yes ☐ No
- Frequent headaches? ☐ Yes ☐ No
- Snoring? ☐ Yes ☐ No
- Bad Breath? ☐ Yes ☐ No
- Any problems with taste and smell? ☐ Yes ☐ No

History of sinus or nose surgery? ☐ Yes ☐ No

Previous Ear, Nose and Throat physician was Dr. _____

Chest

Have you ever been diagnosed with asthma?	☐ Yes	☐ No	
Do you have shortness of breath?	☐ Yes	☐ No	
Do you have a cough?	☐ Yes	☐ No	
Have you ever had wheezing?	☐ Yes	☐ No	
Have you ever had a chest x-ray?	☐ Yes	☐ No	
Have you ever performed a pulmonary function test?	☐ Yes	☐ No	
Have you ever used an inhaler?	☐ Yes	☐ No	
If ***YES***, name _____			
Date last used: _____			
Did it help?	☐ Yes	☐ No	
How many times a month/week do you use your inhaler _____			
Do you have heartburn?	☐ Yes	☐ No	
Have you ever been diagnosed as having gastroesophogeal reflux?	☐ Yes	☐ No	

ALLERGY TESTING

Have you ever had allergy testing?	☐ Yes	☐ No	
If YES, testing was done by			
Dr. In (month) (year)			
Have you ever received allergy shots?	☐ Yes	☐ No	
Still on allergy shots?	☐ Yes	☐ No	
Shots are received how often?			
Allergy shots have helped?	☐ Yes	☐ No	
Any minor reaction to shots?	☐ Yes	☐ No	
Any major reaction to shots?	☐ Yes	☐ No	
If severe reaction to shots please explain:			

PAST MEDICAL HISTORY

Other chronic health conditions:	**PHYSICIAN'S NOTES**

since	
since	

PAST ALLERGY HISTORY			
Are you allergic to any (if ***YES***, please list):	☐ Yes	☐ No	**PHYSICIAN'S NOTES**
Food	☐ Yes	☐ No	
Medicine	☐ Yes	☐ No	
Insect Venom	☐ Yes	☐ No	

HOSPITALIZATION AND SURGICAL HISTORY				
Past Hospitalizations:	Year		For	
	Year		For	
	Year		For	
Past Surgeries:	Year		For	
	Year		For	
	Year		For	
Past Emergency Visits:	Year		For	

CURRENT MEDICATIONS			
Please list all current medications:	Dose	Times per Day	

FAMILY HISTORY					
	Allergies	Asthma	Frequent Cough	Frequent Infections	**PHYSICIAN'S NOTES**

Mother					
Father					
Brother(s)					
Sister(s)					
Grandmother(s)					
Grandfather(s)					
Other chronic conditions such as cystic fibrosis, emphysema, recurrent hives or swelling, lupus, rheumatoid arthritis, etc. (please list):					

HABITS

Do you smoke? ☐ Yes ☐ No	
How many years? _____	
How many packs per day? _____	

CURRENT ENVIRONMENT

Current occupation is: _____						**PHYSICIAN'S NOTES**
Do you live in a: ☐ House ☐ Apartment ☐ Condominium ☐ Townhouse ☐ Mobile Home ☐ Other						
Do you have:						
Cats	☐ Yes	☐ No	Cigarette smoke	☐ Yes	☐ No	
Dogs	☐ Yes	☐ No	Forced air heat	☐ Yes	☐ No	
Birds	☐ Yes	☐ No	Air conditioning	☐ Yes	☐ No	
Other pets	☐ Yes	☐ No	Mold growth	☐ Yes	☐ No	
Down comforter	☐ Yes	☐ No	Air cleaner	☐ Yes	☐ No	
Regular mattress	☐ Yes	☐ No	Ceiling fans	☐ Yes	☐ No	
Curtains/Drapes	☐ Yes	☐ No	Carpets or rugs	☐ Yes	☐ No	

REVIEW OF SYSTEMS (circle if present)

Fever Weight Loss Joint Swelling or pain Eye Problems Hormone problems Skin problems Blood count problems Nerve or psychiatric problems Throat infections Urinary or bladder problems Stomach upset Heart problems or high blood pressure