

LONGMONT CLINIC - ALLERGY AND ASTHMA

ENVIRONMENTAL HISTORY FORM

NAME _____ DATE OF BIRTH _____

Please answer the following questions to help us determine the cause of your allergy symptoms.

YOUR HOME

What type of home do you live in? Single family home _____ Apartment, condominium or townhouse _____

What is the approximate age of your home? _____

How many years have you lived at this residence? _____

What other parts of the country have you lived in? _____

What type of heating system do you have? Forced air _____ Oil _____ Hot water _____

Electric _____ Wood or pellet stove or fireplace _____

What type of cooling system do you have? Air conditioner _____ Swamp cooler _____

Do you have a humidifier?..... YES NO

Is your home mostly carpeted?..... YES NO

Is your home located in a rural or farm setting?..... YES NO

Do you have water damage, mold or mildew in the home?..... YES NO

YOUR BEDROOM

Do you have bedding or upholstered furniture moved here from another part of the country?..... YES NO

Which state? _____

Do you have bedding or pillows made of feathers?..... YES NO

Do you have carpeting or large area rugs in bedroom?..... YES NO

Synthetic _____ Cotton _____ Wool _____

YOUR BED

Are you sleeping on a bed on the floor or on a mattress made of foam or feathers?..... YES NO

Is your pillow made of foam or feathers?..... YES NO

Do you have extra pillows or stuffed animals in bed?..... YES NO

INDOOR PETS

Do you have any indoor pets with fur or feathers? (dogs, cats, birds, rodents)..... YES NO

Type _____

Do any of your pets sleep in your bed or bedroom?..... YES NO

SMOKING HISTORY

Have you ever smoked?..... YES NO

Number of years in lifetime _____

Average number of packs per day in lifetime _____

Are you still smoking?..... YES NO

Are you ready to quit smoking?..... YES NO

Have you been or are you being exposed to second hand smoke?..... YES NO

Number of years in lifetime _____

OCCUPATION/LEISURE ACTIVITIES

Are you exposed to smoke, dust, pollens, chemical fumes, farm products, animals or pollutants at work or during leisure activities?..... YES NO

If so, please list _____

THANK YOU!

If you have chest or asthma symptoms please complete the reverse side of this sheet.



ASTHMA QUESTIONAIRE

Please answer the following questions "yes" or "no":

- When I walk or do simple chores, I have trouble breathing or I cough..... YES NO
- When I perform heavier work, such as walking up hills and stairs or doing chores that at involve lifting, I have trouble breathing or I cough..... YES NO
- Sometimes I avoid exercising or taking part in sports like jogging, swimming, tennis or aerobics because I have trouble breathing or I cough..... YES NO
- I have been unable to sleep through the night without coughing attacks or shortness of breath..... YES NO
- Sometimes I can't catch a good, deep breath..... YES NO
- Sometimes I make wheezing sounds in my chest..... YES NO
- Sometimes I cough a lot..... YES NO
- Dust, pollen or pets make my breathing more difficult..... YES NO
- Cold weather makes my breathing more difficult..... YES NO
- My breathing gets worse when I'm around tobacco smoke, fumes or strong odors..... YES NO
- When I catch a cold, it often goes into my chest..... YES NO
- I had one or more emergency visits to a doctor in the last year because of breathing problems..... YES NO
- I had one or more overnight hospitalizations due to breathing problems in the last year.... YES NO
- My breathing problem controls my life more than I would like..... YES NO
- I feel tension or stress because of my breathing problem..... YES NO
- I worry that my breathing problem affects my health or may even shorten my life..... YES NO
- I feel that I use my inhaler too often..... YES NO
- Sometimes I don't like the way my asthma medicine(s) makes me feel..... YES NO
- My asthma medicine(s) doesn't control my asthma..... YES NO
- | DAYTIME ASTHMA SYMPTOMS | NIGHTTIME ASTHMA SYMPTOMS |
|--|---------------------------------------|
| Symptoms less than 2 times a week YES NO | Less than 2 times a month..... YES NO |
| Daily symptoms..... YES NO | More than once a week..... YES NO |
| Continuous symptoms..... YES NO | Frequent night symptoms..... YES NO |

Longmont Clinic Allergy Department

New Patient Medical Information

Date of Visit _____

Name _____ Age _____ Date of Birth _____

Reason for visit? _____

Who referred you? _____

Current Medications (including over the counter, vitamins, and herbals):

_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____
_____	dosage _____	how many times a day _____

Please write remaining medications on back of this form.

Allergies to medications: _____

Past Allergy Therapy/Testing: _____

Have you done immunotherapy in the past? _____ date _____

Past allergy medications taken (include over the counter) _____

Current & Past Medical Problems/Illness/Injuries

_____	date _____
_____	date _____
_____	date _____
_____	date _____
_____	date _____

Prior Surgeries:

_____	date _____
_____	date _____
_____	date _____
_____	date _____
_____	date _____

Family History:	Age	Medical Problems/Allergies	Age of death	Cause of death
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Father: _____

Mother: _____

Brothers: _____

Sisters: _____

Social History:

Marital Status: S M D Separated Children _____ Occupation _____

How many years have you lived in Colorado? _____

Do you smoke or chew tobacco? Y / N How often? _____

Did you smoke or chew tobacco in the past? Y / N How often and when? _____

Exposed to second hand smoke? Y / N currently or in the past? _____

Drug/alcohol use? Y / N How often? _____

Longmont Clinic Allergy Department
Review of Systems

Name _____			Date of Birth _____		
<u>Constitutional Systems</u>			Incontinence or dribbling	No	Yes
General health lately OK?	No	Yes	Kidney stones	No	Yes
Recent weight change	No	Yes	<u>Musculoskeletal</u>		
Fever	No	Yes	Joint pain	No	Yes
Fatigue	No	Yes	Joint stiffness or swelling	No	Yes
Headaches	No	Yes	Weakness of muscles or joints	No	Yes
<u>Eyes</u>			Muscle pain or cramps	No	Yes
Eye disease or injury	No	Yes	Back pain	No	Yes
Wear glasses or contacts	No	Yes	Cold extremities	No	Yes
Blurred or double vision	No	Yes	Difficulty walking	No	Yes
Glaucoma	No	Yes	<u>Neurological</u>		
<u>Ears/Nose/Mouth/Throat</u>			Frequent or recurring headaches	No	Yes
Hearing loss or ringing in ears	No	Yes	Light headedness or dizzy	No	Yes
Earaches or drainage	No	Yes	Convulsions or seizures	No	Yes
Chronic sinus problems or rhinitis	No	Yes	Numbness or tingling sensations	No	Yes
Nose bleeds	No	Yes	Tremors	No	Yes
Mouth sores	No	Yes	Paralysis	No	Yes
Bleeding gums	No	Yes	Stroke	No	Yes
Bad breath or bad taste in mouth	No	Yes	Head injury	No	Yes
Sore throat or voice change	No	Yes	<u>Psychiatric</u>		
Swollen glands in neck	No	Yes	Memory loss or confusion	No	Yes
Snoring or sleep apnea	No	Yes	Nervousness	No	Yes
<u>Cardiovascular</u>			Depression	No	Yes
Heart trouble	No	Yes	Insomnia	No	Yes
Chest pain or angina pectoris	No	Yes	<u>Endocrine</u>		
Palpitations	No	Yes	Glandular or hormone problem	No	Yes
Shortness of breath w/walking or lying flat	No	Yes	Thyroid disease	No	Yes
Swelling of feet, ankles, or hands	No	Yes	Diabetes	No	Yes
<u>Respiratory</u>			Heat or cold intolerance	No	Yes
Chronic or frequent coughs	No	Yes	<u>Hematologic/Lymphatic</u>		
Spitting up blood	No	Yes	Slow to heal after cuts	No	Yes
Shortness of breath	No	Yes	Bleeding or bruising tendency	No	Yes
Asthma or wheezing	No	Yes	Anemia	No	Yes
<u>Gastrointestinal</u>			Phlebitis	No	Yes
Loss of appetite	No	Yes	Past transfusions	No	Yes
Change in bowel movements	No	Yes	Enlarged glands	No	Yes
Nausea or vomiting	No	Yes	<u>Allergic/Immunologic</u>		
Frequent diarrhea	No	Yes	History of adverse reaction to:		
Painful bowel movements or constipation	No	Yes	Penicillin or other antibiotics	No	Yes
Rectal bleeding or blood in stool	No	Yes	Morphine, Demerol, narcotics	No	Yes
Abdominal pain or heartburn	No	Yes	Novocain or other anesthetics	No	Yes
Peptic ulcer (stomach or duodenal)	No	Yes	Aspirin or other pain remedies	No	Yes
<u>Genitourinary</u>			Tetanus antitoxin, other vaccines	No	Yes
Frequent urination	No	Yes	Milk, egg, peanut, seafood, chocolate, or other foods _____	No	Yes
Burning or painful urination	No	Yes	Latex	No	Yes
Blood in urine	No	Yes	Insect stings	No	Yes
Change in force of strain when urinating	No	Yes	Cat, dog, horse, feathers	No	Yes
			Hives, if so to what _____	No	Yes
			Diagnosed with eczema or dermatitis	No	Yes