

Complete the following information. Please put an X in each box that relates to your problems.

Patient Name: _____ Date of Birth: _____ Date of First Visit: _____
 (Please Print)

Were you referred by a physician or other provider? no yes If yes, who _____

Briefly state what symptoms are bringing you here: _____

Upper Respiratory Tract (Nose, Sinus, Ear, and Eye) Problems

Note: If No Upper Respiratory Tract problems, Check Here And Go To Page 2 - Lower Respiratory Tract.

When did these symptoms first begin? _____

- sneezing itching nose
- nasal congestion stuffiness
 - if so: right side left side both sides
- runny nose; what color is the mucus? _____
- post-nasal drip drainage cough sore throat
- decreased or absent sense of smell
- nose bleeds snoring bad breath
- nasal polyps; if so: past present
- frequent colds; if so, how many per year? 1-5 5-10
- headaches/sinus pain; if so, location: _____
 - how often per month: 1-5 5-10 more than 10
- recurrent ear infections ear plugging/popping/fullness
- hearing loss; if so, was hearing tested? yes no

- septum deviated septum perforated
 - previous nose injury; if so, was nose broken? yes no
 - previous nasal or sinus surgery; if so, when? _____
 - recurrent or chronic sinus infections; if so, how many per year?
 - 0-4 over 4
 - sinus x-rays or sinus CT scan done
 - if so, when? _____
 - result normal abnormal
 - ENT evaluation; if so, when? _____
 - name of doctor: _____
- Eyes: itch red watering swollen lids
- fatigue/tired poor concentration
 - other: _____

Symptoms Caused Or Aggravated By:

- cold air weather change
- temperature change damp/humid weather
- odors/scents/fragrance tobacco smoke
- your workplace or school aspirin/related medications
- dusting/vacuuming musty odors/mold
- yard work pollens being outdoors
- animals, list: _____
- other: _____

- Year-round symptoms? yes no
- Season(s) in which symptoms are worst: ("X" all that apply)
- spring summer fall winter
- Frequency of upper respiratory tract symptoms:
- daily _____ times per week _____ times per month
 - other: _____
- Symptoms interfere with: sleep exercise/activity
- school (missed days) work (missed days)
 - how often do symptoms interfere? _____
- Symptoms are: improving worsening unchanged

List medications tried for upper respiratory symptoms (include prescription and over-the-counter oral medications and nasal sprays):

Name of Medication	Past	Current	Did it work?	
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no

Office Use Only

Name _____

Lower Respiratory Tract (Chest, Lung) Problems

Note: If No LOWER Respiratory Tract Problems, Check Here And Go To Page 3.

When did chest symptoms first begin? _____

- chronic or recurrent cough; if so, cough is:
 - dry loose coughing spells
 - if loose, is mucus coughed up? yes no
 - if yes, mucus color is: _____
 - occur at night during sleep: yes no
 - coughed up blood: yes no
- wheezing; when breathing out in
- chest tightness or pressure throat tightness
- shortness of breath difficulty taking a full breath
- awakening at night with chest symptoms yes no
- asthma diagnosed by a physician? age: _____
- emergency room visit(s) for asthma; if so, how many times? _____
 - date of last ER visit: _____
- hospitalized for asthma; if so, number of times? _____
 - date of last hospitalization: _____
- intensive care unit for asthma; when: _____
 - if so, were you on a ventilator/respirator? yes no

- oral steroids (Prednisone, Medrol, Prelone, etc.) taken for asthma
 - if so, number of times taken per year:
 - 1 2 - 5 greater than 5
 - date of last use: _____
- history of recurrent bronchitis
- history of recurrent pneumonia
- history of recurrent croup
- previous chest x-ray or chest CT scan; if so, when? _____
 - result: normal abnormal
- peak flow meter used; if so, best reading: _____
- pulmonary function (lung) test: yes no
- pulmonary (lung specialist) evaluation; when: _____
 - specialist's name: _____
- other symptoms (list): _____

Symptoms Caused Or Aggravated By:

- colds/upper respiratory infections sinus infections
- exertion/exercise; type: _____
- cold air weather change temperature change
- odors/scents/fragrance tobacco smoke
- eating/drinking heartburn/acid reflux
- emotional stress/anger laughing/crying
- your workplace or school
- aspirin/related medications
- dusting/vacuuming musty odors/mold
- yard work pollens being outdoors
- animals, list: _____
- other: _____

Year-round symptoms? yes no

Season(s) in which symptoms are worst: ("X" all that apply)

- spring summer fall winter

Frequency of lower respiratory tract symptoms:

- daily _____ times per week _____ times per month
- other: _____

Symptoms interfere with: sleep exercise/activity

- school (missed days) work (missed days)

• how often do symptoms interfere? _____

Symptoms are: improving worsening unchanged

List medications tried for lower respiratory symptoms (include prescription and over-the-counter oral, inhaled, and injected medications):

Name of Medication	Past	Current	Did it work?
<input type="checkbox"/> Albuterol <input type="checkbox"/> inhaler <input type="checkbox"/> nebulizer How often used? _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes <input type="checkbox"/> no
_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes <input type="checkbox"/> no

Office Use Only

Name: _____

Skin Problems

Note: If No Skin Problems, Check Here And Go To Page 4.

When did skin symptoms first begin? _____ Eczema started when: _____

- itching
- welts/hives When did welts/hives start? _____
- excessively dry, scaly skin
- skin swelling
- face
- lips
- tongue /throat
- hands/feet
- irritated red patches
- weepy, oozing rash
- recurrent skin infections
- other symptoms (list): _____

Location of rash: _____

Frequency of above symptoms: daily _____ times per week _____ times per month other: _____

Are skin symptoms present year-round? yes no

Season(s) in which above symptoms are worst: spring summer fall winter

Has a physician diagnosed your rash? yes no

• if yes, what was the diagnosis? hives eczema contact dermatitis other: _____

Have you seen a dermatologist for your skin problems? yes no

• if yes, name of doctor: _____ when seen: _____

List everything that causes or aggravates your skin symptoms:

List medications tried for above symptoms (include prescription and over-the-counter oral medications, creams, and ointments):

Name of Medication	Past	Current	Did it work?	
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> yes	<input type="checkbox"/> no

Office Use Only

Name: _____

Previous Allergy Evaluation(s): no yes Date(s): _____

Skin testing: no yes Blood testing for allergy: no yes

Results of previous allergy testing (bring records if available): _____

Were you allergic? no yes

- if allergic, was it to: animals dust/mites pollen mold food
- other (list): _____

Allergist: Name: _____ State: _____

Previous allergy injection(s): no yes

If yes, date(s) started: _____ date(s) stopped: _____

- were allergy injections effective? no yes not sure
- adverse reactions to allergy injection(s)? no yes; if yes, list: _____

Insect Sting Reactions: no yes

If yes, insect(s) causing reaction: _____

- symptoms: large swelling at site hives breathing problems dizzy/lightheaded
- other (list): _____

When did this occur? _____ Epinephrine/adrenlin device prescribed? no yes

Drug Allergies / Intolerances: no yes

Name Or Type Of Medication

Reaction(s) Noted

When Did Reaction Occur? Age or Date

Is The Medication Completely Avoided?

_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no

Food Allergies / Intolerances: no yes

Food

Reaction(s) Noted

When Did Reaction Occur? Age or Date

Is The Food Completely Avoided?

_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no
_____	_____	_____	<input type="checkbox"/> yes	<input type="checkbox"/> no

Latex Rubber Allergies / Intolerances: no yes

If yes, explain: _____

Name: _____

Past Medical History:

Flu vaccine: no yes; if yes, when? _____ Pneumonia vaccine: no yes; if yes, when? _____

T.B. test: no yes; if yes, when? _____; result: positive negative

Heart problems: no yes; if yes, describe: _____

Blood pressure problems: no yes; if yes, treatment: _____

Other medical problems: _____

Birth history (if patient is a child): normal premature _____

Hospitalization(s): none _____

Surgery(s): none _____

Serious injury(s): none _____

All Other Current Medications (Include Over-The-Counter And Supplements)

Medication	Dosage	Frequency (how often)

Family History:

Do any close family members have the following? **Check the appropriate box below:** (even if mild or outgrown)

	Father	Mother	Brothers	Sisters	Children
Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migraine headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other diseases that run in the family:

Immune problems yes no

Cystic Fibrosis yes no

Emphysema yes no

Family member: _____

Social History:

Have you ever smoked? no yes; if yes, for how many years: _____

If yes, are you a current smoker? yes no; if no, when did you quit: _____

• how much do/did you smoke? Number of packs per day less than 1/2 1/2 1 2 or more

Do you consume alcoholic beverages? no yes; if yes, how much: _____

Use marijuana or other "recreational" drugs? no yes; if yes, how often: _____

Name: _____

General

- Good general health
- Weight gain; past year: _____ lbs.
- Weight loss; _____ lbs.
 - dieting yes no
- Excessive tiredness
- Excessive thirst /drinking
- Recurrent fever
- Recurrent night sweats
- Pregnant planning within year
- Cancer history
 - type: _____

Eyes

- Dry eyes
- Wear contact lenses
- Cataracts
- Glaucoma

Mouth /Throat

- Excess dryness of mouth
- Excessive throat mucus*
- Throat clearing*
- Hoarseness or voice problems*
- Sensation of something stuck in throat*

Heart

- Palpitation or pounding of heart
- Irregular heart beat
- Angina /chest pain /tightness
- History of heart attack
- Thrombophlebitis/blood clots
- Swollen ankles /feet

Gastrointestinal

- Difficulty swallowing*
- Heartburn /acid indigestion /reflux
 - stomach acid coming up*
 - frequency; _____
- History of ulcer
- Frequent spitting up or wet burps (infants)
- Hiatal hernia
- Recurrent vomiting
- Frequent diarrhea
- Bloody or black stools
- "Greasy" / bulky stools
- Liver disease: _____
- History of Hepatitis
 - Hepatitis Type: A B C
 - if so, when diagnosed _____
- Other intestinal problems; _____
- Evaluation by GI specialist
 - when; _____
 - name: _____

Genitourinary

- Kidney trouble
- Protein or sugar in urine
- Prostate problem
- Frequent urination

Musculoskeletal

- Painful or stiff joints
- Swollen joints
- Rheumatoid Arthritis
- Osteoarthritis (age /injury related)
- Osteoporosis
- Scoliosis /spine curvature

Endocrine

- Thyroid gland problems
- Adrenal gland problems
- Diabetes

Neurologic

- Headache
 - migraine other
 - how often; _____
- Hyperactivity /ADD /ADHD
- Dizzy spells
- Fainting spells
- Convulsions /epilepsy /seizures
- Head or neck injury
- Insomnia
- Depression
- Anxiety
- Ever see a psychiatrist /psychologist?
 - Currently see one

Blood /Lymphatic

- Blood disorder: _____
- Anemia
- Bruise easily
- Swollen lymph nodes
 - if so, where? _____
- Previous blood transfusion
- Risk factors for AIDS
- Testing for HIV
 - if so, result: positive negative
- Other symptoms or medical problems (list)

Name: _____

Environmental History

How long has patient lived in Colorado? _____

What other states/countries has patient lived in? _____

Instructions: Please fill out completely.

Primary Home (for patient living in two homes, see bottom of page 8)

Location: city suburb rural farm Approximate elevation: _____

Type: house townhouse condominium apartment mobile home other: _____

Age of home: _____ Length of time in home: _____ (months, years).

Number of people, and who live in home: _____ List (patient, mother, son, etc.): _____

Construction

Basement: none finished unfinished walkout earth moisture problem

Crawl space: none yes moisture problem

Heating and Cooling

Heat: forced air furnace hot water or radiant heat electric baseboard kerosene propane
 woodburning stove woodburning fireplace gas fireplace

Cooling system: none central air window air conditioner swamp cooler attic fan

Central filter type: none fiberglass HEPA electrostatic

Frequency of filter change or cleaning: _____

Room air filter: none HEPA electrostatic ion generator other: _____

Location of room air filter: _____

Air Ducts cleaned: no yes; if yes, when: _____

Mold and Moisture

Humidifier: none furnace cold-mist ultrasonic steam Frequency of cleaning: _____

Water leak(s): none past current If past or current leak(s), where? _____

musty odor visible mold; location: _____

Cleaning

Frequency of dusting: daily 2-3 times per week 1 time per week every 2-4 weeks

Frequency of vacuuming: daily 2-3 times per week 1 time per week every 2-4 weeks

Type of vacuum: upright canister water-filled HEPA

Type of vacuum bag: permanent disposable

Name: _____

Environmental History (continued)

Patient's Bedroom

Location: basement main floor upper floor

Flooring: wood tile linoleum area rug wall to wall carpet; if so: shag pile

Window Coverings: none curtains drapes shades blinds

In warm seasons, sleep with windows: open closed

Beds (consider all beds in room):

Mattress: innerspring foam waterbed bunk futon

Pillow: feather (down) foam synthetic

Other bedding items: feather (down comforter) cotton synthetic

Is mattress from another state? no yes; if yes, what state? _____

Pets

no yes

	Number	How Long Owned?	Type/Breed	Outside	Inside	Allowed in Bedroom	Sleep in Bedroom
<input type="checkbox"/> Dog(s)	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Cat(s)	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other(s)	_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Smokers (at your home)

No one patient mother father husband wife other: _____

Other Environments

	Number of days per week spent	Animals	Smokers
Daycare	_____	<input type="checkbox"/>	<input type="checkbox"/>
Relatives' Homes	_____	<input type="checkbox"/>	<input type="checkbox"/>
School/Work	_____	<input type="checkbox"/>	<input type="checkbox"/>
Vacation Home	_____	<input type="checkbox"/>	<input type="checkbox"/>
Friends that you visit	_____	<input type="checkbox"/>	<input type="checkbox"/>

Hobbies / Interests

Indoor: _____

Outdoor: _____

Occupation / School / Daycare

Type of work/school/daycare: _____

Kinds of materials exposed to at work/school: _____

Travel/Vacations

Do you travel frequently? no yes; if yes, to where? _____

Second Home (for patient living in two homes, please complete the following):

If patient is a child, parent/guardian in second home: _____ Time spent in second home: _____

Smokers: _____ Pets: _____

Other exposures: _____

List anything in the environment that you feel causes symptoms: _____

