ALLERGY and ASTHMA SPECIALISTS of KANSAS CITY

Name: _____ Referred By: _____

Date of Birth _____ Today's Date: _____ Primary Physician: _____

PATIENT PLEASE COMPLETE THIS SIDE

I. The Reason I Am Here Is:

_____
_____
_____
_____

II. Please Check What Best Describes Your Symptoms:

		MAJOR PROBLEM	LESS OF A PROBLEM	NOT A PROBLEM
NOSE:				
	Stuffy Nose	_____	_____	_____
	Runny Nose	_____	_____	_____
	Sneezing / Itchy Nose	_____	_____	_____
	Drainage Down Throat	_____	_____	_____
	Discolored Drainage	_____	_____	_____
	Facial Pressure	_____	_____	_____
	Sore Throat	_____	_____	_____
	Headaches	_____	_____	_____
	Snoring	_____	_____	_____
	Loss of Sense of Smell	_____	_____	_____
EYES:	Itchy	_____	_____	_____
	Watery	_____	_____	_____
	Red	_____	_____	_____
	Pain	_____	_____	_____
	Vision Change	_____	_____	_____
EARS:	Ear Infections	_____	_____	_____
	Itchy	_____	_____	_____
	Popping	_____	_____	_____
	Hearing Loss	_____	_____	_____
	Balance Problems	_____	_____	_____
CHEST:	Chest Tightness	_____	_____	_____
	Wheezing	_____	_____	_____
	Coughing	_____	_____	_____
	At Night	_____	_____	_____
	With Exertion	_____	_____	_____
	Awakening Due to Asthma	_____	_____	_____
	Problems With Exertion	_____	_____	_____
FOOD:	Vomiting	_____	_____	_____
	Abdominal Pains	_____	_____	_____
	Diarrhea	_____	_____	_____
SKIN:	Eczema	_____	_____	_____
	Hives	_____	_____	_____
	Other	_____	_____	_____
OTHER:	Bee Sting Reaction	_____	_____	_____

SYMPTOMS ARE TRIGGERED BY: (**Circle** all that apply)

SEASON: Spring Summer Fall Winter

TIME OF DAY: Morning Evening Night

TRAVEL DUST SMOKE STRESS MY JOB POLLEN DAMPNESS

FUMES EXERCISE SCHOOL GRASS PETS WEATHER CHANGES

FOOD ASPIRIN OTHER:_____

PHYSICIAN NOTES

L2<3 L3,4,5>4 LOC. QUAL, SEV, DUR, TIMING, CONTENT, MOD FAC, ASSOC, SYM

NOSE: **Rhinitis:** Age or Year of Onset: _____
Number of Sinus Infections Last Year: _____
ENT Evaluation _____
CT Sinus _____

Onset / Frequency / severity

Co-Morbidity
Otitis / Sinusitis
Sleep Disorder / Polyps
Triggers

Current Medications

CHEST:

DX Asthma y/n _____ Years Ago
Current Frequency Symptoms

Hosp: _____

ER Visits: _____
School / work days lost in last year: _____
Pneumonia: _____
Asthma awakenings per month: _____
Beta-agonist use per week: _____
Courses of steriods in last year: _____
PFM and Personal Best _____

Triggers:
Season
Pets
Dust
Mold
Exercise
GERD
ASA/NSAID
Cold
Infection
Occupation
Irritants

Current Medications

CXR date: _____ Result _____
PFT date: _____ Result _____
TB Test date: _____ Result _____
Pneumovax/Prevnar _____ Flu Shot _____

EYES:
Onset / Frequency / Severity
Treatment/OTC?

EARS:
Number of Infections Last Year: _____
Prophylaxis/PE tubes/Tand or A/Snoring/Apnea
Courses Antibiotics per Year: _____

FOOD: Type: _____
Reaction: _____
Severity: _____
Date: _____

SKIN:
Hives: _____ 1st Episode: _____ Frequency: _____
Severity: _____ Agrav: _____
Date of Onset: _____
Relieved By _____
Size:_____ Duration:_____ Trigger:_____ Meds:_____

OTHER: Describe: _____

PATIENT PLEASE COMPLETE THIS SIDE

III. HEADACHE HISTORY (Answer Only If Headaches Are a Problem)

How long have you had them? _____

Where does it hurt? _____

Can you predict when they are coming? YES_____ NO_____

What brings them on? _____

Do you get nauseated with them? YES_____ NO_____

What does it take to get over one? _____

_____

What medications have you treated with? _____

_____

Have you seen a neurologist? YES_____ NO_____

IV. PAST MEDICAL HISTORY

HOSPITALIZATIONS:

AGE OR YEAR	FOR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

SURGERIES:

AGE OR YEAR	FOR
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

DRUG ALLERGIES:

NAME OF DRUG	SYMPTOMS
_____	caused _____
_____	caused _____
_____	caused _____
_____	caused _____

LATEX ALLERGY:

_____ caused _____

BIRTH HISTORY and CHILDHOOD HISTORY (If Under 18 Years of Age):

Complicated Labor and Delivery? _____

Prolonged Hospitalization in Newborn? _____

Immunizations? _____

_____

Growth and Development? _____

Name: _____

PHYSICIAN NOTES

DUR: _____

LOC: _____

MED: _____

NEURO: signs or symptoms

Lab: _____

Neurology consult: _____

Name: _____

PATIENT PLEASE COMPLETE THIS SIDE

IV. PAST MEDICAL HISTORY (Continued)

OTHER CHRONIC HEALTH CONDITIONS:

CONDITION — AGE or YEAR

_____ since _____
_____ since _____
_____ since _____
_____ since _____

LIST OF ALL CURRENT MEDICATIONS:

V. PAST ALLERGY HISTORY

Previous Allergy Testing? ____ Yes ____ No

If Yes, please answer the following:

Tested by Dr. _____in _____(YEAR)

Previous Allergy Shots? ____ Yes ____ No

Still on Shots? ____ Yes ____ No

Shots Every _____ Weeks Now

Allergy Shots Helped? ____ Yes ____ No

Reaction to Allergy Shot? ____ Yes ____ No

VI. FAMILY MEDICAL HISTORY (Check if Applicable):

	Allergies	Asthma	Cystic Fibrosis	TB	Other Illness (Name)
Father	____	____	____	____	_____
Mother	____	____	____	____	_____
Brother(s)	____	____	____	____	_____
Sister(s)	____	____	____	____	_____
Children	____	____	____	____	_____
Grandparents	____	____	____	____	_____
Aunt(s)	____	____	____	____	_____
Uncle(s)	____	____	____	____	_____
Cousin(s)	____	____	____	____	_____

VII. SOCIAL

MARITAL STATUS: ___Single ___Married ___Divorced ___Separated

CURRENT OCCUPATION: _____

CHILD: School _____ Daycare _____

LEVEL OF EDUCATION: _____

ALCOHOL / DRUG USE: _____

Do you smoke cigarettes? _____ Yes _____ No

____ Never Smoked
____ Smoked Previously, but Quit _____ Years Ago
____ Smoked Previously (____ Packs per Day for ____ Years)
____ Smoke Now (____ Packs per Day for ____ Years)

PHYSICIAN NOTES

PFSH
L1,2 0
L3 1
L4,5 3

Name: _____

PATIENT PLEASE COMPLETE THIS SIDE

VIII. ENVIRONMENTAL

HOME CONSTRUCTION: ____ Apartment ____ Mobile Home
____ House ____ Other

AGE OF HOME: _____ Years

HEAT: ____ Forced Air ____ Hot Water ____ Space Heater
____ Wood ____ Kerosene ____ Gas
____Electric

AIR CONDITIONING: ____ Central ____ Window
____ None ____ Humidifier

FLOORS (BEDROOM): ____ Wood ____ Carpet
____ Linoleum ____ Other

BEDDING: ____ Innerspring Mattress ____ Plastic Cover
____ Waterbed
____ Feather Pillow

BASEMENT: ____ Damp ____ Dry ____ None

PETS: ____ Dogs (Number _____) ____ Inside ____ Outside
____ Cats (Number _____) ____ Inside ____ Outside
____ Other Animals (Please List): _____
_____

SMOKE EXPOSURE: _____At Home (Number of Smokers: _____)
_____At Work

IX. REVIEW OF SYSTEMS (Check all that apply):

____ Fever
____ Weight Loss (_____Pounds Lost)
____ Weight Gain (_____Pounds Gained)
____ Skin Problems Besides Eczema
____ Joint Swelling or Pain
____ Blood Count Problems (Anemia, etc.)
____ Eye Problems (Cataract, Glaucoma, etc.)
____ Throat Infections
____ Heart Problems / High Blood Pressure
____ Stomach Upset
____ Urinary Bladder Problems
____ Nervous or Psychiatric Problems
____ Thyroid Disorder
____ Diabetes
____ Pregnant or Pregnancy Planned
____ Other (Describe _____)

Name of Person Completing This Form:

_____

Relationship If Not Patient:

_____

PHYSICIAN NOTES

L2 1
L3 ≥ 2-9
L4,5 10