

Allergy & Asthma

ADULT GENERAL HISTORY

JEFFREY R. LEIPZIG, M.D.

Print name: _____ Date of birth: _____ AGE _____

LAST FIRST

MEDICATIONS:

List current prescription/ non-prescription medications (include vitamins, pain, relievers, oral contraceptives, and cold medicines). None

Dose (Milligrams) Frequency (times/ day)

ALLERGIES:

Have you had a reaction to latex/ adhesive tape/ rubber? **YES NO**
 Have you had hives, skin rash, breathing problems or other allergic reactions to medications? **YES NO** If yes, please specify below:

Describe Allergic Reaction

Please identify other medications you have recently used: _____ Are there other medications that you do not tolerate due to unpleasant side-effects? _____

REVIEW OF SYSTEMS:

Please check **YES / NO** on the following responses and **CIRCLE** all that apply.

| | YES | NO |
|---|-----|----|
| Have you had relapsing or persistent fever(>101 ⁰)? | | |
| Has your illness seriously affected your work or personal life? | | |
| Does your nose run, get stuffy, or itch? | | |
| Have you had any nasal trauma or injury? | | |
| Are you bothered by strong odors, smoke, or weather changes? | | |
| Are you bothered frequently with a cough or shortness of breath? | | |
| Are you frequently stopped from exercising from shortness of breath, coughing or wheezing? | | |
| Are you frequently awakened at night with shortness of breath, coughing or wheezing? | | |
| Are you coughing up sputum or blood? | | |
| Do you have problems with falling/staying asleep or sleep apnea? | | |
| Do you have any serious reactions to bee stings, drugs or foods? | | |
| Have you had a change in your weight > 10 pounds over the last six mths? | | |
| Do you have significant facial pain or recurrent headaches? | | |
| Do you have spells, seizures, or trouble moving an arm or leg? | | |
| Do you have any problems with your eyes (double vision or blurred vision)? | | |
| Do you have any problems with hearing, dizziness, or hoarseness? | | |
| Are you aware of any enlarged glands (lymph nodes)? | | |
| Do you experience chest pain/ pressure, rapid or irregular beating of the heart or have known heart problems or valve problems? | | |
| Do you have difficulty eating, drinking or swallowing? | | |
| Are you often troubled by indigestion, heartburn, nausea, vomiting? | | |
| Are you aware of any recent change or blood in your bowel movement? | | |
| Do you have pain or burning when urinating? Or blood in your urine? | | |
| Do you have a skin rash, sore, excessive bruising or a changing mole? | | |
| Do you suffer from anemia or other blood problems? | | |
| Do you often feel cold or hot in a room that is comfortable for others? | | |
| Do you feel you may be at risk for HIV/ AIDS? | | |
| Do you have pain or stiffness in your joints or back? | | |
| Are you experiencing a stressful situation? | | |
| Do you feel depressed, nervous or tired much of the time? | | |

ROS otherwise negative

PAST MEDICAL HISTORY:

Have you ever been **HOSPITALIZED**? Yes No Describe: _____

Have you ever been to the **EMERGENCY ROOM**? Yes No Describe: _____

SOCIAL HISTORY:

Are you currently single, married, widow, or divorced?

Occupation / work exposure _____

Do you use **tobacco** now? **YES NO** Type and daily amount _____ How long? _____
 In the past? **YES NO** Type and daily amount _____ How long? _____ Year quit
 Do you use **alcoholic** beverages? **YES NO** Type and daily amount _____ How long? _____
 In the past? **YES NO** Type and daily amount _____ How long? _____ Year quit
 Do you use **caffeine**? **YES NO** Type and daily amount _____
 Do you participate in physical activity? **YES NO** Type and daily amount _____

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 LAST FIRST

Indicate whether you have had any of the following : **ILLNESSES, CONDITIONS OR SURGERIES**

| | | | |
|--------------------------|-------------------------------|----------------------|------------------------|
| Cancer | Liver Disease / Hepatitis | Anxiety / depression | Bone / Joint |
| Stroke/TIA | Kidney / Bladder | Head / Brain | Back |
| Glaucoma/Cataracts | Diabetes | Tonsils | Female Organs |
| Thyroid disease | High blood fats / cholesterol | Vascular | Sinus / Nose/ Ear |
| High blood pressure | Abnormal bleeding | Liver / Gall Bladder | Lung disease / surgery |
| Heart disease / surgery | Blood problems (anemia) | Stomach / Bowel | Skin disease |
| Vein trouble/blood clots | Joint disease | Appendix | Hernia / Prostate |

Other : _____

Have you ever received a **BLOOD TRANSFUSION?** Yes No If yes, give year: _____

Are your **immunizations up to date?** Yes Measles Mumps Rubella Polio Pneumonia
 Hepatitis B Tetanus/ Diphtheria within last 10 years Influenza(Flu) within last year

FAMILY HISTORY: Are you adopted? YES NO Other members of family with allergies, asthma, skin problems.

Parents: _____ Siblings: _____ Children: _____

ENVIRONMENTAL HISTORY:

| | |
|--|--------------------------------|
| 1. Do you live in home, or apartment? Approx. Year built | How long have you lived there? |
| 2. What type of air conditioning do you have? (central, window unit) Are you better in air conditioning? | |
| 3. What type of heating do you have? (gas, electric, steam, wood burning, oil, etc.) | |
| 4. Do you have a dog? # _____ Inside / Outside | In bedroom? Worse around dogs? |
| 5. Do you have a cat? # _____ Inside / Outside | In bedroom? Worse around cats? |
| 6. Do you have other indoor / outdoor animals? | Are you exposed to roaches? |
| 7. What type of bedding do you sleep on? (boxspring and mattress, waterbed, etc.) | |
| 8. What type of pillow do you have? (feather, foam, polyester) | |
| 9. Do you have dust mite proof covers on your bed? <input type="checkbox"/> No | |
| 10. What type of flooring is in your bedroom? (carpet, area rug, hardwood) | Any hobbies? |
| 11. Do you have a damp basement? | |
| 12. Where do you spend your awake time? (office, industrial, outdoor, retired, etc.) | |

Patient Comments / Concerns: