PIKES PEAK
Allergy & Asthma

Medical History Form

Patient Name: **Date of Birth:**

NASAL/SINUS SYMPTOMS. Check all that apply:

☐ *Sneezing* ☐ *Itchy nose* ☐ *Nasal stuffiness* ☐ *Runny nose* ☐ *Post nasal drip* ☐ *Sore throat* ☐ *Snoring*
☐ *Decreased/absent sense of smell* ☐ *Nose bleeds* ☐ *Sinus pain/pressure* ☐ *Headache* ☐ *Ear pain/pressure*

How often do these nasal symptoms occur:

Date of last sinus x-ray: Done where:

Date of last sinus CAT scan: Done where:

ENT Specialist (name of physician):

EYE SYMPTOMS. Check all that apply:

☐ *Itchy* ☐ *Redness* ☐ *Watery* ☐ *Burning* ☐ *Dry*

How often do these eye symptoms occur: Do you wear contacts:

RESPIRATORY SYMPTOMS. Check all that apply:

☐ *Chronic cough* ☐ *Chest tightness/pressure* ☐ *Shortness of breath* ☐ *Wheezing* ☐ *Gasping at night*

How often do these respiratory symptoms occur:

Previous Diagnosis(es): ☐ *Recurrent bronchitis* ☐ *Pneumonia* ☐ *Recurrent croup* ☐ *Asthma* ☐ *Emphysema*

Supplies used: ☐ *Peak flow meter* ☐ *Spacer for inhaler* ☐ *Nebulizer* ☐ *Home oxygen* ☐ *CPAP*

Have you ever been hospitalized for asthma: Date of last admission/ER visit:

Date of last chest x-ray/CAT scan: Done where:

Do you smoke: If you are an ex-smoker, when did you quit:

If yes, how many packs per day: If yes, for how many years:

Have you had your heart evaluated: When: By Whom:

SKIN SYMPTOMS. Check all that apply:

☐ *Skin swelling* ☐ *Hives/welts* ☐ *Eczema* ☐ *Recurrent skin infections* *Other:*

How often do these skin symptoms occur:

OTHER SYMPTOMS. Check all that apply:

☐ *Fever* ☐ *Fatigue* ☐ *Weight loss* ☐ *Weight gain* ☐ *Nausea* ☐ *Vomiting* ☐ *Diarrhea* ☐ *Heartburn*
☐ *Recurrent bladder infections* ☐ *Joint pain* ☐ *Muscle aches* ☐ *Heat/cold intolerance* ☐ *Dizziness*

SYMPTOM TRIGGERS. Check all that apply:

☐ *Cold air* ☐ *Exercise* ☐ *Fragrances/perfumes* ☐ *Smoke* ☐ *Cats* ☐ *Dogs* ☐ *Weather changes* ☐ *Dust*
☐ *Stress* ☐ *Emotions (laughing/crying)* ☐ *Medications* ☐ *Upper respiratory infections* ☐ *Windy days*
☐ *Damp/humid weather* *Other:*

Medical History Form (continued)

Patient Name: **Date of Birth:**

Name of any medications that did not help with symptoms listed on the previous page:

Name of any medications that helped with symptoms listed on the previous page:

PAST MEDICAL HISTORY. Check all that apply:

☐ *High blood pressure* ☐ *Thyroid disease* ☐ *Diabetes* ☐ *Cancer* ☐ *Heart disease* ☐ *Migraine headaches*
☐ *Glaucoma* ☐ *Cataracts* ☐ *Heartburn/reflux* ☐ *High cholesterol* ☐ *Chronic pain* ☐ *Arthritis* ☐ *Stroke*
☐ *Kidney stones* ☐ *Menstrual problems* ☐ *Osteoporosis* ☐ *Seizures* ☐ *Anxiety* ☐ *Depression*

Other (please describe):

PAST SURGICAL HISTORY/HOSPITALIZATIONS. Please describe:

MEDICATIONS. Please list any medications you are currently taking:

FAMILY MEDICAL HISTORY. Check all that apply:

Mother:	☐ *Asthma*	☐ *Allergies*	☐ *Eczema*	☐ *Sinus problems*	☐ *Cancer*	☐ *Heart disease*
Father:	☐ *Asthma*	☐ *Allergies*	☐ *Eczema*	☐ *Sinus problems*	☐ *Cancer*	☐ *Heart disease*
Siblings:	☐ *Asthma*	☐ *Allergies*	☐ *Eczema*	☐ *Sinus problems*	☐ *Cancer*	☐ *Heart disease*
Children:	☐ *Asthma*	☐ *Allergies*	☐ *Eczema*	☐ *Sinus problems*	☐ *Cancer*	☐ *Heart disease*
	☐ *Asthma*	☐ *Allergies*	☐ *Eczema*	☐ *Sinus problems*	☐ *Cancer*	☐ *Heart disease*

SOCIAL HISTORY

How long have you lived in Colorado:

Where else have you lived:

Structure: ☐ *House* ☐ *Apartment/Townhome* ☐ *Mobile home* ☐ *Air-conditioning* ☐ *Swamp cooler*

Pets: ☐ *None* ☐ *Indoor Cats* ☐ *Outdoor Cats* ☐ *Indoor Dogs* ☐ *Outdoor Dogs* *Other*:

Are there smokers in the home:

How much alchohol do you drink:

Occupation:

Hobbies:

If a child, are they in daycare: How often: Are there pets: