Laura Ispas, MD

ALLERGY ASTHMA & IMMUNOLOGY INSTITUTE

INITIAL PATIENT MEDICAL HISTORY

PATIENT NAME:
DATE OF BIRTH:

Address:_____

City:_____State:_____Zip: _____

Home Phone:_____Work Phone:_____ Age:_____

Height:_____Weight:_____ Sex: ❑Male ❑Female Married: ❑Yes ❑No

Insurance Company / HMO Name: _____

Employer: _____

How did you hear about us? (If it was an online location, please specify which website)

_____

Were you referred to this office by another physician? ❑Yes ❑No

If you were referred by a physician, what is his or her specialty? (check one)

❑Family physician ❑Allergist ❑Internist ❑Pediatrician ❑Other_____

Please give his or her name, address and phone number:

Physician Name:_____

Address:_____

City:_____State:_____Zip: _____

Phone Number:_____Fax: _____

Who is your primary care physician? (Name, address and phone number)

Physician Name:_____

Address:_____

City:_____State:_____Zip: _____

Phone Number:_____Fax: _____

Chief Complaint **Please describe in your own words the primary medical problem which prompted you to seek an evaluation today:**

❑Hay fever
❑Asthma
❑Food allergies
❑Itching
❑Recurrent sinus infections
❑Rash
❑Food intolerance
❑Hives
❑Eczema
❑Cough

Please detail:

_____

_____

Asthma Severity

CHECK ONE THAT MOST APPLIES

Symptom frequency	❑ <1 x per week	❑ 2-6 x per week	❑ Daily	❑ Always
Nighttime asthma symptom frequency	❑ <2 x per month	❑ 2-4 x per month	❑ 2-4 x per week	❑ Almost every night
Do asthma symptoms wake you up at night?	❑ Never	❑ Sometimes	❑ Usually	❑ Always
Do you have asthma episodes/attacks after sleep?	❑ Never	❑ Sometimes	❑ Usually	❑ Always
Do you have asthma episodes/attacks after physical activity?	❑ Never	❑ Sometimes	❑ Usually	❑ Always
Do your symptoms interfere with school or work?	❑ Never	❑ Sometimes	❑ Usually	❑ Always
Do your symptoms go away after the use of an inhaler?	❑ Yes (Which inhaler?_____			❑ No
How often do you use extra inhaler treatments?	❑ Never	❑ Sometimes	❑ 2-5 times week	❑ Every day

Do you have frequent asthma episodes?	❑ Yes	❑ No
Do your symptoms ever cause you to stop physical activity?	❑ Yes	❑ No
Have your symptoms forced you to change your occupation or quit work?	❑ Yes	❑ No
Have your symptoms required frequent trips to the Emergency Room?	❑ Yes	❑ No
Have your symptoms resulted in any hospitalizations?	❑ Yes	❑ No
Have your symptoms resulted in respiratory arrest, intubation and the use of a mechanical ventilator?	❑ Yes	❑ No

Respiratory History

What respiratory diagnosis (if any) have you been given by physicians? (Note: you may have more than 1 diagnosis)

DIAGNOSIS	DATE WHEN SYMPTOMS BEGAN	DIAGNOSIS	DATE WHEN SYMPTOMS BEGAN
❑ None		❑ Heart failure	_____
❑ Asthma	_____	❑ Pneumonia	_____
❑ Bronchitis	_____	❑ Sleep apnea	_____
❑ Chronic bronchitis	_____	❑ Vocal cord dysfunction	_____
❑ COPD	_____	❑ Other _	_____
❑ Emphysema	_____	❑ Other _____	_____

When did you first have respiratory symptoms? month_____ year _____

Trigger Factors

Which of the following *trigger factors* cause a worsening of your respiratory condition? (check all that apply)

- ❑Colds, influenza, Bronchitis
- ❑Occupational exposures
- ❑Weather changes
- ❑Pollens (cut grass, wooded areas)
- ❑Cold air
- ❑Air pollution
- ❑Emotions or stress
- ❑Menstrual cycles
- ❑Sinus infections
- ❑Dogs
- ❑Cats
- ❑Damp, musty area
- ❑Sinus infections
- ❑Exercise
- ❑Alcoholic beverages
- ❑Cigarette smoke
- ❑Perfumes, hair sprays
- ❑Laughter
- ❑Nonsteroidal anti-inflammatory agents
- ❑Menstrual cycles

Shortness of Breath

How long can you walk before you have to stop because of shortness of breath?

❑<3 min ❑5 min ❑10 min ❑15 min ❑>15 min

How many stairs can you climb before you have to stop because of shortness of breath?

❑<5 ❑10 ❑15 ❑20 ❑25 ❑30 ❑>30

Do you wake up at night with shortness of breath? ❑Yes ❑No

Have you experienced: (check all that apply)

Excessive daytime sleepiness?	❑Yes	❑No
Difficulty concentrating during the daytime?	❑Yes	❑No
Loud snoring?	❑Yes	❑No
Restless sleep?	❑Yes	❑No
Headaches in the morning?	❑Yes	❑No
Waking up at night due to your snoring?	❑Yes	❑No

Cough

If you have a *cough*, please describe further:

Is your cough daily or frequent? ❑Daily ❑Frequent

Does your cough wake you up at night? ❑Yes ❑No

If yes, times per month? _____

Do you have frequent episodes of cough associated with phlegm production?	❑Yes	❑No
Have you coughed on most days, for 3 consecutive months or more?	❑Yes	❑No
Do you cough up blood?	❑Yes	❑No
Do you have indigestion?	❑Yes	❑No

For how long have you been bothered by a cough? _____

Sinus History

Do you have any of the following? (check all that apply)

❑Nasal stuffiness	❑Sinus headaches	❑Nighttime cough
❑Facial pain	❑Nasal discharge	❑Loss of sense of smell/taste
❑Runny nose	❑Postnasal drip	
❑Bad breath	❑Sinus congestion or pressure	

Have you been treated with antibiotics for sinusitis? ❑Yes ❑No

If yes, how often have you been treated in the past year? _____

Please list medication(s): _____

_____

_____

Have you ever been told you have nasal polyps? ❑Yes ❑No

Have you ever received sinus CT (CAT scan) or x-rays? ❑Yes ❑No

Date obtained: _____

Results: _____

_____

_____

Have you ever had sinus surgery? ❑Yes ❑No

If yes, date:

Medication Allergies

Please list the names of any medication(s) which have caused you to have an allergic reaction.

NAME OF MEDICATION(S)	ALLERGIC REACTION(S)

Family History

Has anyone in your family (parents, siblings, aunts, uncles, grandparents) had: (check all that apply)

❑Heart disease ❑Emphysema ❑Hypertension ❑Cystic fibrosis ❑Diabetes

❑Allergies ❑Cancer ❑Asthma ❑Arthritis

Date of most recent influenza vaccine (flu shot) _____

Date of pneumococcal vaccine _____

Environmental History

Do you live in a house, apartment or trailer? _____

How old is the home? _____ **How long have you lived there?** _____

Has there been any water leakage or damage in your home? ❑ Yes ❑ No

Do you live in a home made of concrete block framing? ❑ Yes ❑ No

Type of heating: (check one) ❑ forced air ❑ gas ❑ radiant ❑ electric ❑ wood burning ❑ other _____

How often are the filters changed? _____

Do you have an electrostatic air filter? ❑ Yes ❑ No ❑ Don't know

Do you have any HEPA filters? ❑ Yes ❑ No ❑ Don't know

Do you have air conditioning? ❑ Yes ❑ No

Do you have a basement? ❑ Yes ❑ No **If yes, is it damp?** ❑ Yes ❑ No

Do you have a fireplace? ❑ Yes ❑ No **If yes, how often is it used?** _____

Check rooms with carpeting: ❑ bedroom ❑ living room ❑ TV room ❑ other

Type of pillow or comforter (check all that apply): ❑ feather ❑ dacron ❑ other

Do you have pillow and mattress dust-proof encasements? ❑ Yes ❑ No

How many stuffed toys do you have in your bedroom? _____

Do you have any pets? (check all that apply) ❑ cat ❑ dog ❑ hamster ❑ bird ❑ guinea pig ❑ other

Where do they sleep? _____

Smoking History

Does anyone smoke in your home? ❑ Yes ❑ No

Have you ever smoked cigarettes? ❑ Yes ❑ No

If yes, how old were you when you started smoking? _____

Are you still smoking cigarettes? ❑ Yes ❑ No

If no, how old were you when you quit smoking? _____

How many packs per day did you (do you) average? _____

Do you smoke cigars? ❑ Yes ❑ No

If yes, how long have you been smoking cigars? _____

Habits

Do you ever drink alcoholic beverages? ❑ Yes ❑ No

If yes, number of drinks per day _____

Have you ever used recreational drugs? ❑ Yes ❑ No

If yes, what drugs? _____

Use of Medications

Please list all current ORAL and INHALED medications prescribed by your doctor and any nonprescription medicine(s) you are taking:

Medications: _____

_____

_____

Urgent Treatment

How often do you use your rescue/quick-relief medicine for an asthma attack? _____

Does it help? ❑ Yes ❑ No

How often in the last year have you been to your physician's office for unscheduled visits because of asthma? _____

How often in the last year have you been to the Emergency Room for treatment of asthma? _____

List all hospitalizations for asthma in the past 2 years:

_____

Past Medical History

Please check any of the following you have ever experienced:

❑ Thyroid disease
❑ Migraine/headache
❑ Heart disease
❑ Hypertension
❑ Pneumonia
❑ Cancer
❑ Hiatal hernia
❑ Ulcers
❑ Hepatitis
❑ Diabetes
❑ Stroke
❑ Osteoporosis
❑ Any severe infections

Review of Symptoms

Please circle any of the following symptoms which you are currently experiencing, or which have caused you *serious* problems in the past.

General:	Fever, weight loss, weight gain, night sweats, severe itching, loss of appetite, fatigue, cold intolerance, heat intolerance.
Eye/Ear/Nose & Throat:	Loss of vision, blurry vision, cataracts, glaucoma, loss of hearing, itching in ear, ringing in the ears, loss of balance, loss of sense of smell, loss of sense of taste, excessive tearing, dry eyes, itchy eyes, conjunctivitis, ear infections, dry mouth, postnasal drainage.
Lymph Glands:	Glandular swelling, glandular tenderness.
Heart:	Chest pain, palpitations, swelling of ankles, inability to lie flat in bed.
Intestinal Tract:	Nausea, vomiting, heartburn, indigestion, trouble swallowing liquids or food, abdominal pain, constipation, diarrhea, excessive gas, food intolerances, gallstones, acid or sour taste in mouth, blood in stool.
Reproductive:	Irregular periods, skipped periods, unusual vaginal bleeding, menopause, infertility, miscarriages, impotence, unplanned pregnancy, planned pregnancy.
Urinary:	Kidney stones, inability to urinate, prostate problems, kidney infections.
Rheumatologic & Orthopedic:	Early morning joint stiffness, joint swelling, joint pain, gout, low back pain, osteoporosis, fractured bones.
Skin:	Skin rash, hives, eczema, skin tumors or growths, excessive hair loss.
Neurologic:	Fainting spells, severe headaches, epilepsy (seizures), difficulty with memory, inability to concentrate.

Please elaborate on *any* symptoms which are particularly bothersome to you: _____

_____

_____