ARCADIA Allergy & Asthma
SAN TAN Allergy & Asthma

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NEW PATIENT HISTORY

Name:_____**Dob:**_____**Date:**_____

Chief Complaints

	Adverse Drug Reaction		FPIES		Reaction to insect stings/bites
	Angioedema (swelling)		Headache		Recurrent infections
	Asthma		Immune Deficiency		Runny nose
	Atopic Dermatitis (Eczema)		Itching/Itchy		Sneezing
	Cough		Itchy eyes		Urticaria (hives)
	Environmental allergies		Nasal Congestion		Wheezing
	Eosinophilic Eosphagitis		Possible Allergic Reaction		Other, *please specify:*
	Food allergies/Intolerances		Rash		

Medication Allergies	**Describe Reaction**

Other Allergies (**Food, Insect, Latex**)	**Describe Reaction**

Patient's Past Medical History (PLEASE CHECK ALL THAT APPLY)

	ALLERGY/IMMUNOLOGY		**ENDOCRINE**		**GENITOURINARY**
	Allergic Rhinitis (hayfever)		Diabetes (Type1 or 2)		Kidney disease/failure/stones
	Anaphylactic Reactions		Hyperthyroidism		Prostate disease
	Common Variable Immune Deficiency		Hypothyroidism		**INTEGUMENTARY**
	Immunizations up to date		**ENT (Ears, Nose, Throat)**		Chickenpox
	Primary immune deficiency		Chronic ear infections		Eczema
	Previously seen an allergist:		Chronic sinus infections		Urticaria
	If yes, who?		Chronic Adenoiditis		Psoriasis
	Previously on immunotherapy:		Chronic Tonsillitis		**MUSCULOSKELETAL**
	If yes, how many years?		Sleep Apnea		Arthritis
	CANCER		Vocal Cord Dysfunction		Carpal tunnel syndrome
	If yes, what kind?		**EYE OR VISION**		Gout
	CARDIOVASCULAR		Cataracts		Fibromyalgia
	Abdominal aortic aneurysm (AAA)		Corrective Eyewear		Tendinitis
	Arterial stenosis (AS)		Glaucoma		**RESPIRATORY**
	Bradycardia/Tachycardia		**GASTROINTESTINAL**		Asthma
	Congestive heart failure (CHF)		Abdominal pain syndrome		Bronchitis
	Deep vein thrombosis (DVT)		Eosinophilic Esophagitis		COPD
	Heart murmur		Gastro-esophageal reflux disease (GERD)		Pneumonia
	Myocardial Infarction (MI)		Irritable bowel syndrome (IBS)		**NEUROLOGICAL**
	Mitral Valve Prolapse (MVP)		Peptic ulcer disease		Autism Spectrum Disorder
	Pacemacker				Dementia

PATIENTS SURGICAL HISTORY & HOSPITALIZATIONS

Year	*Type*	*Hospital*

Family History Please fill in the family member's initials as they apply.
Key: Mother: M, Father: F, Brother: B, Sister: S, Daughter: D, Son: Sn
Maternal Grandparent: MGP, Paternal Grandparent: PGP

Adopted limited history		Food Allergy	
Allergic Rhinitis/Hayfever		GERD (reflux)	
Asthma		Headaches/Migraine	
Anaphylaxis		Heart Disease	
Arthritis		High blood pressure	
Autoimmune disorders		Hives or Swelling	
Cancer		Immune Deficiency	
Celiac Disease		Latex Allergy	
Heart disease		Lung Problems (COPD)	
Cystic fibrosis		Seizures	
Dermatitis/Eczema		Sinus Infections	
Diabetes		Thyroid Disease	
Drug Allergy		*Other, Please Specify*	
Eosinophilic esophagitis			

Social History
Marital status: ☐ Child ☐ Married ☐ Divorced ☐ Separated ☐ Single ☐ Widowed ☐ Significant Other
If child patient lives with: ☐ Both Parents ☐ Mother ☐ Father ☐ Other Family Member ☐ Foster Family
Custody: ☐ Joint custody ☐ Primary Custody with Father ☐ Primary Custody with Mother

Occupation: _____Hobbies/Sports:_____

Tobacco Exposure: Do you smoke ☐ yes ☐ no ☐ Past smoker, Exposed to second hand smoke ☐ yes ☐ no

Environmental History:
Current Home: ☐ House ☐ Apartment ☐ Mobile home
Home setting: ☐ Farm ☐ Rural ☐ Suburban ☐ Urban/City
Flooring: ☐ Carpet ☐ Tile/Linoleum ☐ Wood
Air Conditioning/Heating: ☐ Central A/C ☐ Swamp cooler ☐ Wall unit ☐ Wood stove
What type of pets do you have: ☐ Cat ☐ Dog ☐ Bird ☐ Gerbil/Guinea Pig ☐ Horse ☐ Other_____
☐ Pet lives outside ☐ Pet lives inside ☐ Pet sleeps in bedroom

Name of Medication	**Dosage**	**Frequency**

Review Of Systems (Please check all that apply to you in the last few months)

	CARDIOVASCULAR		GASTROINTESTINAL		NEUROLOGICAL
	Chest Pain		Abdominal pain		Numbness/Tingling
	Heart Palpitations		Blood in stool		Stroke
	Hypertension		Constipation		Tremors
	EARS, NOSE, THROAT (ENT)		Diarrhea		**PSYCHIATRIC**
	Itchy nose, sneezing, runny nose		Heartburn		Agitation
	Frequent ear infections		Nausea		Anxiety
	Frequent sore throats		Recent loss of appetite		Memory Loss
	Nasal congestion		Vomiting		Mood Disorder
	Nasal Polyp(s)		**GENERAL**		Nervousness
	Post-nasal drip		Chills		Problems Concentrating
	Hearing loss		Dizziness		Stress
	Ringing in ears		Fatigue		**RESPIRATORY**
	Snoring		Fever		Chest Congestion
	Trouble swallowing		Headache/Migraines		Chest Tightness
	ENDOCRINE		Weight loss		Cough
	Cold Intolerance		Weight gain		Difficulty breathing
	Decreased energy/endurance		**GENITOURINARY**		Pneumonia
	Easily fatigued		Bed wetting		Shortness of Breath
	Frequent thirst		Blood in urine		Wheezing
	Heat intolerance		Frequent urination		**SKIN**
	EYE OR VISION		Frequent UTIs		Eczema
	Blurred vision		Pain when urinating		Hives
	Double vision		**MUSCULOSKELETAL**		Rash
	Eye pain		Joint pain/stiffness		Itching
	Itchy eyes		Weakness of muscles/joints		Psoriasis
	Watery eyes				

Asthma Assessment (If the patient has a diagnosis of asthma)
Write the number of each answer in the score box provided. Then, add up the score boxes to get the total.

Child between 4-11 years: Have your child answer questions 1-4, and then complete questions 5-7 on your own

1. How is your asthma today?

(0)Very Bad	(1) Bad	(2) Good	(3) Very Good	Score =

2. How much of a problem is your asthma when you run, exercise, or play sports?

(0)It's a big problem, I can't do what I want to do	(1) It's a problem and I don't like it	(2) It's a little problem but it's okay	(3) It's not a problem	Score =

3. Do you cough because of your asthma?

(0)Yes, all of the time	(1) Yes, most of the time	(2) Yes, some of the time	(3) No, none of the time	Score =

4. Do you wake up during the night because of your asthma?

(0)Yes, all of the time	(1) Yes, most of the time	(2) Yes, some of the time	(3) No, none of the time	Score =

5. During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

(5) Not at all	(4) 1-3 days	(3) 4-10 days	(2) 11-18 days	(1) 19-24 days	(0) Everyday	Score =

6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

(5) Not at all	(4) 1-3 days	(3) 4-10 days	(2) 11-18 days	(1) 19-24 days	(0) Everyday	Score =

7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?

(5) Not at all	(4) 1-3 days	(3) 4-10 days	(2) 11-18 days	(1) 19-24 days	(0) Everyday	Score =
						Total =

Patients 12 years and older:

1.In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school, or at home?

(1) All of the time	(2) Most of the time	(3) Some of the time	(4) A little of the time	(5) None of the time	Score =

2. During the past 4 weeks, how often have you had shortness of breath?

(1) More than once a day	(2) Once a day	(3) 3-6 times a week	(4) 1-2 times a week	(5) Not at all	Score =

3. During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

(1) 4 or more nights a week	(2) 2-3 nights a week	(3) Once a week	(4) Once or twice	(5) Not at all	Score =

4. During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication?

(1) 3 or more times per day	(2) 1-2 times per day	(3) 2-3 times per week	(4) Once a week or less	(5) Not at all	Score =

5. How would you rate your asthma control during the past 4 weeks?

(1) Not controlled at all	(2) Poorly Controlled	(3) Somewhat controlled	(4) Well controlled	(5) Completely controlled	Score =

Total =