Laura Ispas, MD

ALLERGY ASTHMA & IMMUNOLOGY INSTITUTE

Jill Ham, NP

INITIAL PATIENT MEDICAL HISTORY

PATIENT NAME:
DATE OF BIRTH:

Address:_____

City:_____State:_____Zip:_____

HomePhone:WorkPhone:Age:

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

Insurance Company /HMOName:

_____

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:

PhysicianName:_____

_____Address:_____

_____ City:_____State:

_____Zip:_____

PhoneNumber:_____Fax:_____

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

PhysicianName:_____

_____Address:_____

_____ City:_____State:

_____Zip:_____

PhoneNumber:_____Fax:_____

Chief Complaint **Pleasedescribeinyourownwordstheprimarymedicalproblemwhichpromptedyou toseekanevaluationtoday:**

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

Please detail:

_____

_____

Asthma Severity

CHECK ONE THAT MOST APPLIES

Symptomfrequency	❑ <1xperweek	❑ 2-6xperweek	❑ Daily	❑ Always
Nighttimeasthmasymptomfrequency	❑ <2xpermonth	❑ 2-4xpermonth	❑ 2-4xper week	❑ Almost everynight
Doasthmasymptomswakeyouupatnight?	❑ Never	❑ Sometimes	❑ Usually	❑ Always
Do you have asthma episodes/attacks aftersleep?	❑ Never	❑ Sometimes	❑ Usually	❑ Always
Do you have asthma episodes/attacks afterphysicalactivity?	❑ Never	❑ Sometimes	❑ Usually	❑ Always
Do your symptoms interfere with school orwork?	❑ Never	❑ Sometimes	❑ Usually	❑ Always
Do your symptoms go away after the use ofaninhaler?	❑ Yes(Whichinhaler?_____			❑ No
How often do you use extra inhaler treatments?	❑ Never	❑ Sometimes	❑ 2-5times week	❑ Everyday

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 ofamechanicalventilator?	❑ 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 WHENSYMPTOMSBEGAN	DIAGNOSIS	DATEWHENSYMPTOMSBEGAN
❑ None		❑ Heartfailure	_____
❑ Asthma	_____	❑ Pneumonia	_____
❑ Bronchitis	_____	❑ Sleepapnea	_____
❑ Chronic bronchitis	_____	❑ Vocal corddysfunction	_____
❑ COPD	_____	❑ Other__	_____
❑ Emphysema	_____	❑ Other_____	_____

Whendidyoufirsthaverespiratorysymptoms?month_____year _____

Trigger Factors

Whichofthefollowing*triggerfactors*causeaworseningofyourrespiratorycondition? (checkallthatapply)

❑Colds, influenza, Bronchitis
❑Occupational exposures
❑Weather changes
❑Damp, musty area
❑Sinus infections
❑Exercise

❑Pollens (cut grass, wooded areas)
❑Cold air
❑Air pollution
❑Emotions or stress
❑Menstrual cycles
❑Sinus infections
❑Dogs
❑Cats

❑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 ❑ 5min ❑ 10min ❑ 15min ❑ >15min

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

❑ <5 ❑ 10 ❑ 15 ❑ 20 ❑ 25 ❑ 30 ❑ >30

Doyouwakeupatnightwithshortnessofbreath? ❑ Yes ❑ No

Have you experienced: (check all that apply)

Excessivedaytimesleepiness?	❑ Yes	❑ No
Difficultyconcentratingduringthedaytime?	❑ Yes	❑ No
Loudsnoring?	❑ Yes	❑ No
Restlesssleep?	❑ Yes	❑ No
Headaches inthemorning?	❑ Yes	❑ No
Wakingupatnightduetoyoursnoring?	❑ Yes	❑ No

Cough

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

Isyourcoughdailyorfrequent? ❑ Daily ❑ Frequent

Doesyourcoughwakeyouupatnight? ❑ Yes ❑ No

Ifyes,timespermonth?_____

Doyouhavefrequentepisodesofcoughassociatedwithphlegmproduction?	❑ Yes	
❑ NoHaveyoucoughedonmostdays,for3consecutivemonthsormore?	❑ Yes	
❑ NoDoyoucoughupblood?	❑ Yes	❑ No
Do youhaveindigestion?	❑ Yes	❑ No

For how long have you been bothered by acough?_____

Sinus History

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

❑Nasal stuffiness
❑Facial pain
❑Runny nose
❑Bad breath

❑Sinus headaches
❑Nasal discharge
❑Postnasal drip
❑Sinus congestion or pressure

❑Nighttime cough
❑Loss of sense of smell/taste

Haveyoubeentreatedwithantibioticsforsinusitis? ❑ Yes ❑ No

Ifyes,howoftenhaveyoubeentreatedinthepastyear?

_____Pl

easelistmedication(s):_____

_____

_____

Haveyoueverbeentoldyouhavenasalpolyps? ❑ Yes ❑ No

HaveyoueverreceivedsinusCT(CATscan)orx-rays? ❑ Yes ❑ No

Dateobtained:_____

Results:_____

_____

_____

Haveyoueverhadsinussurgery? ❑ Yes ❑ No

Ifyes,date:

Medication Allergies

Pleaselistthenamesofanymedication(s)whichhavecausedyoutohavean allergicreaction.

NAMEOFMEDICATION(S)	ALLERGIC REACTION(S)

Family History

Hasanyoneinyourfamily(parents,siblings,aunts,uncles,grandparents)had: (checkallthatapply)

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

❑ Allergies ❑ Cancer ❑ Asthma ❑ Arthritis

Dateofmostrecentinfluenzavaccine(flushot)_____

Dateofpneumococcalvaccine_

Environmental History

Doyouliveinahouse,apartmentortrailer?_____

How old isthehome?_____Howlonghaveyoulivedthere?_____

Hastherebeenanywaterleakageordamageinyourhome? ❑ Yes ❑ No

Doyouliveinahomemadeofconcreteblockframing? ❑ Yes ❑ No

Typeofheating:(checkone) ❑ forcedair ❑ gas ❑ radiant ❑ electric ❑ woodburning ❑ other

_____H

owoftenarethefilterschanged?

_____D

oyouhaveanelectrostaticairfilter? ❑Yes ❑No ❑Don'tknow

DoyouhaveanyHEPAfilters? ❑Yes ❑No ❑Don'tknow

Doyouhaveairconditioning? ❑Yes ❑No

Doyouhaveabasement? ❑Yes ❑No If yes, is it damp? ❑Yes ❑No

Doyouhaveafireplace? ❑Yes ❑No Ifyes,howoftenisitused? _____

Checkroomswithcarpeting: ❑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

Howmanystuffedtoysdoyouhaveinyourbedroom?_____

Doyouhaveanypets?(checkallthatapply) ❑cat ❑dog ❑hamster ❑bird ❑guineapig ❑other

Wheredothey sleep? _____

Smoking History

Doesanyonesmokeinyourhome? ❑Yes ❑No

Haveyoueversmokedcigarettes? ❑Yes ❑No

Ifyes,howoldwereyouwhenyoustartedsmoking?_____

Areyoustillsmokingcigarettes? ❑Yes ❑No

Ifno,howoldwereyouwhenyouquitsmoking?_____

Howmanypacksperdaydidyou(doyou)average? _____

Doyousmokecigars? ❑Yes ❑No

Ifyes,howlonghaveyoubeensmokingcigars? _____

Habits

Doyoueverdrinkalcoholicbeverages? ❑Yes ❑No

Ifyes,numberofdrinksperday_____

Haveyoueverusedrecreationaldrugs? ❑Yes ❑No

If yes, whatdrugs? _____

Use of Medications

PleaselistallcurrentORALandINHALEDmedicationsprescribedbyyourdoctorandanynonprescription medicine(s)youaretaking:

Medications:_____

_____

_____

Urgent Treatment

Howoftendoyouuseyourrescue/quick-reliefmedicineforanasthmaattack?_____
Doesithelp? ❑ Yes ❑ No

How often in the last year have you been to your physician's office for unscheduledvisitsbecauseofasthma?_____

How often in the last year have you been to the Emergency Room for treatmentofasthma?_____

Listallhospitalizationsforasthmainthepast2years:

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

Pleasecircleanyofthefollowingsymptomswhichyouarecurrentlyexperiencing, orwhichhavecausedyou*serious*problemsinthepast.

General: Fever, weight loss, weight gain, night sweats, severe itching, loss of appetite,fatigue,coldintolerance, heatintolerance.

Eye/Ear/Nose&Throat: Lossofvision,blurryvision,cataracts,glaucoma,lossofhearing,itchinginear,ringinginthe ears,lossofbalance,lossofsenseofsmell,lossofsenseoftaste,excessivetearing,dry eyes,itchyeyes,conjunctivitis,earinfections,drymouth,postnasaldrainage.

LymphGlands: Glandularswelling,glandulartenderness.

Heart: Chest pain, palpitations, swelling of ankles, inability to lie flat inbed.

IntestinalTract: Nausea,vomiting,heartburn,indigestion,troubleswallowingliquidsorfood,abdominalpain, constipation, diarrhea, excessive gas, food intolerances, gallstones, acid or sour taste in mouth, blood in stool.

Reproductive: Irregularperiods,skippedperiods,unusualvaginalbleeding,menopause,infertility, miscarriages, impotence, unplanned pregnancy, planned pregnancy.

Urinary: Kidneystones,inabilitytourinate,prostateproblems,kidneyinfections.

Rheumatologic&Orthopedic: Earlymorningjointstiffness,jointswelling,jointpain,gout,lowbackpain,osteoporosis, fractured bones.

Skin: Skinrash,hives,eczema,skintumorsorgrowths,excessivehairloss.

Neurologic: Fainting spells, severe headaches, epilepsy (seizures),

difficultywithmemory,inabilitytoconcentrate.

Pleaseelaborateon*any*symptomswhichareparticularlybothersometoyou:_____

_____

_____