The Austin Diagnostic Clinic
Allergy and Immunology Department
Offices in North Austin, South Austin
and Round Rock

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BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT (What is your main concern or symptom):

CHECK SYMPTOMS YOU HAVE OR HAVE HAD:

NASAL SYMPTOMS ☐Past ☐Present

- ☐ Nasal congestion
- ☐ Runny nose
- ☐ Nasal discharge
- ☐ Postnasal drip
- ☐ Snoring
- ☐ Nasal itching
- ☐ Frequent sneezing
- ☐ Frequent nose bleeds
- ☐ Nasal polyps
- ☐ Loss of sense of smell or taste

SINUS ☐Past ☐Present

- ☐ Frequent infections
- ☐ Pressure in a sinuses
- ☐ Postnasal drip
- ☐ Nighttime cough
- ☐ Sinus headache
- ☐ Bad breath

How many times in the last year have you taken an antibiotic for sinus infections? ____
If so, when was the last time? ____________
Have you ever had a CT or CAT scan or x-rays. ☐No ☐Yes
If yes, when was the most recent? ________
Have you ever had sinus surgery? ☐No ☐Yes If yes, date: ____________________

EYE SYMPTOMS ☐Past ☐Present

- ☐ Itching
- ☐ Watery eyes
- ☐ Redness or burning
- ☐ Swelling of the eyelids

FREQUENT EAR INFECTIONS
☐Past ☐Present
Have you had pressure equalization tubes?
☐No ☐Yes
If yes, date: ____________________

EAR SYMPTOMS ☐Past ☐ Present

- ☐ Pain
- ☐ Itching
- ☐ Pressure
- ☐ Loss of Hearing

HEADACHES ☐Past ☐Present

- ☐ Sinus
- ☐ Migraines
- ☐ Tension
- ☐ With menses

Location of headaches

- ☐ Frontal
- ☐ Back of head
- ☐ Temple area
- ☐ One-sided

Is your headache . . .

- ☐ Sharp pain
- ☐ Dull pain
- ☐ Throbbing pain

When you have headaches

- do you have nausea or vomiting? ☐
- do you have difficulty with vision? ☐
- are you bothered by light? ☐
- are you bothered by noise? ☐

Frequency of headaches

- ☐ Daily
- ☐ Weekly
- ☐ Occasionally
- ☐ One-sided

Effective medicines for headaches (list names) ________________________
____

LUNG SYMPTOMS ☐Past ☐Present

- ☐ Asthma
- ☐ Wheezing
- ☐ Chest "colds" or congestion/Bronchitis
- ☐ Shortness of breath at rest
- ☐ Shortness of breath at night
- ☐ Sudden attacks of shortness of breath
- ☐ Pneumonia
- ☐ Croup
- ☐ Cough
- ☐ Coughing up blood

GASTROINTESTINAL ☐Past ☐Present

- ☐ Frequent nausea or vomiting
- ☐ Frequent episodes of diarrhea
- ☐ Heartburn
- ☐ Regurgitation of food
- ☐ Acid or sour taste in your mouth in the morning
- ☐ Abdominal cramping
- ☐ Itchy of mouth or throat
- ☐ Food allergy: List which foods _______

____
____
____

SKIN SYMPTOMS ☐Past ☐ Present

- ☐ Hives
- ☐ Itching
- ☐ Eczema
- ☐ Constant rash

WHICH OF THE FOLLOWING TRIGGER FACTORS MAKE YOUR SYMPTOMS WORSE? (Check all that apply)

- ☐ Bronchitis
- ☐ Colds, influenza
- ☐ Sinus infections
- ☐ Mono-steroidal anti-inflammatory medicine *(such as ibuprofen or neproxin)*
- ☐ Aspirin
- ☐ Exercise
- ☐ Wines, alcoholic beverages
- ☐ Cigarette smoke
- ☐ Perfumes, hairspray, strong odors
- ☐ Cold air
- ☐ Air Pollution
- ☐ Weather changes
- ☐ Cutting grass
- ☐ Cats
- ☐ Dogs
- ☐ Other animals (specify): ____________
  ____
  ____
- ☐ Food additives (specify): ____________
  ____
  ____
- ☐ Laughter
- ☐ Strong emotions and stress
- ☐ Menstrual cycles
- ☐ Damp, musty places
- ☐ House dusting or vacuuming
- ☐ Occupational exposures

Name: ____
Date: ________________________ MRN: ____________

ALLERGY HISTORY

Are your symptoms: ☐ Year-round ☐ Seasonal ☐ Year-round with seasonal increases

If seasonal, which seasons (check all that apply): ☐ Spring ☐ Summer ☐ Fall ☐ Winter

Have you had allergy skin testing? ☐No ☐Yes If yes, by whom? ______________________________

Please list dates and results of these tests: ______________________________

____

Have you had allergy shots? ☐No ☐Yes

Did allergy shots help your symptoms? ☐No ☐Yes

Do you have any other allergy problems, such as latex sensitivity or insect sting allergy (bee, wasps, yellow jacket, hornet or fire ant)?

☐No ☐Yes If yes, please describe: ______________________________

____

WHAT RESPIRATORY DIAGNOSIS (IF ANY) HAVE YOU BEEN GIVEN BY A PHYSICIAN? (check all that apply)

DIAGNOSIS	DATE WHEN SYMPTOMS BEGAN	DIAGNOSIS	DATE WHEN SYMPTOMS BEGAN
☐ COPD/Emphysema	________________	☐ Heart Failure	________________
☐ Asthma	________________	☐ Pneumonia	________________
☐ Asthma, exercise induced	________________	☐ Pulmonary fibrosis	________________
☐ Bronchitis	________________	☐ Tuberculosis	________________
☐ Bronchiectasia	________________	☐ Interstitial disease	________________
☐ Chronic bronchitis	________________	☐ Sleep apnea	________________
☐ Vocal cord dysfunction	________________	☐ Other: ________________	

ASTHMA SEVERITY

CHECK ONE THAT MOST APPLIES

Symptom frequency	☐< 2days/month	☐< 2 days/week	☐2-6 days/week	☐Daily
Do your symptoms go away completely after you use your inhaler?	☐Yes (which inhaler? ________________)			☐Always
How often do you use extra inhaler treatments?	☐< 2 days/month	☐< 2 days/week	☐2-6 days/week	☐Daily

Have you had Emergency or Urgent Care visits for asthma? ☐No ☐Yes If yes, how many in the last year? _________

Have you been admitted to hospital because of asthma? ☐No ☐Yes If yes, how many in the last year? _________

Have you been admitted to an Intensive Care because of asthma? ☐No ☐Yes If yes, when? ________________

Have your asthma symptoms resulted in respiratory arrest, intubation or use of a mechanical ventilator? ☐No ☐Yes

USE OF MEDICATIONS

Please list all current ORAL and INHALED medication prescribed by your doctor and any non-prescription medicines you are taking.

MEDICATION & STRENGTH	HOW MUCH & HOW OFTEN	TAKEN DAILY	MEDICATION & STRENGTH	HOW MUCH & HOW OFTEN	TAKEN DAILY
__________	__________	YES NO	__________	__________	YES NO
__________	__________	YES NO	__________	__________	YES NO
__________	__________	YES NO	__________	__________	YES NO
__________	__________	YES NO	__________	__________	YES NO
__________	__________	YES NO	__________	__________	YES NO
__________	__________	YES NO	__________	__________	YES NO
__________	__________	YES NO	__________	__________	YES NO

What other allergy medicines have you tried? ______________________________

Name: ______________________________

Date: ________________ MRN: __________

PAST MEDICAL HISTORY

List of hospitalizations

DATES OF HOSPITALIZATION	NAME OF HOSPITAL	REASON FOR HOSPITALIZATION
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________
______________________	______________________	______________________

Please list all surgical procedures and the dates they were done

PROCEDURE	DATE
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Please list all known allergies other than those only detected by skin testing

WHAT YOU ARE ALLERGIC TO	REACTION
______________________	______________________
______________________	______________________
______________________	______________________
______________________	______________________

Have you had any of the following?

- ☐ Glaucoma
- ☐ Thyroid disease
- ☐ Migraine headaches
- ☐ Epilepsy
- ☐ Heart disease
- ☐ High blood pressure
- ☐ Pneumonia
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Hiatal hernia
- ☐ Ulcers
- ☐ Irritable bowel syndrome
- ☐ Hepatitis
- ☐ Prostate disease
- ☐ Kidney stones
- ☐ Diabetes
- ☐ Stroke
- ☐ Positive Tuberculin skin test
- ☐ Elevated cholesterol
- ☐ Osteoporosis
- ☐ Any severe infection
- ☐ AIDS or HIV
- ☐ Other significant illness ____________________ ____________________

Do you smoke? ☐No ☐Yes How old were you when you started? _________________ Quit smoking? _________________

Are your immunizations up to date? ☐No ☐Yes Date of last flu shot: ____________ Date of last pneumovac injection: _______________

PREVIOUS TESTS DONE

List any previous testing you have had. Please give approximate dates and results.

	APPROXIMATE DATE	RESULT
☐ Chest x-ray	______________________	______________________
☐ Sinus CT or x-ray	______________________	______________________
☐ Sweat chloride test	______________________	______________________
☐ Pulmonary function tests	______________________	______________________
☐ Barium swallow	______________________	______________________
☐ Ph probe test	______________________	______________________
☐ Nasopharyngoscopy or laryngoscopy	______________________	______________________
☐ Esophagoscopy	______________________	______________________
☐ Bronchoscopy	______________________	______________________
☐ Other	______________________	______________________

Name: ____

Date: ___________________________ MRN: _____________

REVIEW OF SYSTEMS

Please circle any of the following symptoms that you are currently experiencing or that have caused problems in the past.

General:	Fever, weight loss, weight gain, night sweats, severe itching, loss of appetitie, fatigue, cold intolerance, heat intolerance
Eye, Ear, Nose or Throat:	dry eyes, itchy eyes, vision changes, cataracts, glaucoma, light avoidance, eye pain, eye discharge, itchy ears, ear infections, ringing in ears, loss of balance, loss of hearing , deviated septum, nose bleeds, post nasal drip, nasal congestion, sore throat, hoarseness, difficulty, swallowing, recurrent throat infections, loss of smell or taste, dry mouth, dental cavities
Lymph Nodes:	swelling, tenderness
Heart:	chest pain, palpitations, swelling of ankles, inability to lie flat in bed
Intestinal tract:	nausea, vomiting, heartburn, indigestions, trouble swallowing liquids or fluids, abdominal pain, constipation, diarrhea, excessive gas, food intolerance, acid or sour taste in mouth, blood in stool, jaundice
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 stiffness, joint swelling, joint pain, gout, low back pain, osteoporosis, fractured bones
Skin:	skin rash, hives, eczema, skin tumors or growth, excessive hair loss
Neurologic:	fainting spells, sever headaches, epilepsy (seizures), difficulty with memory, inability to concentrate

Provide explanation on any symptoms that are particularly bothersome to you ____

____

FAMILY HISTORY

	Father	**Mother**	**Parent's Siblings**	**Grandparents**	**Patient's Children**	**Other**
Seasonal nasal symptoms (hay fever)	☐	☐	☐	☐	☐	☐
Chronic nasal symptoms	☐	☐	☐	☐	☐	☐
Sinusitis	☐	☐	☐	☐	☐	☐
Recurrent ear infections	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bronchitis (non-smoker)	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Food allergy	☐	☐	☐	☐	☐	☐
Other:						
____________________	☐	☐	☐	☐	☐	☐
____________________	☐	☐	☐	☐	☐	☐

FOR ADULT: Age & gender of your children ____

FOR CHILD: Age & gender of your child's siblings ____

Name: ____

Date: __________________________ MRN: _____________

ENVIRONMENTAL HISTORY

How long have you lived in your current hometown? ________________ How long have you lived in your present home? _____________

How old is the dwelling in which you live? ________________ Do you live in a house, apt or trailer? ______________________________

Has the home flooded before? _________________________

Type of heating: ☐gas forced air ☐radiator ☐electric ☐wood burning ☐other ________________________

How often are the filters changed? ☐Every three months ☐every 6 months ☐once a year ☐less often than once a year

Do you have an electrostatic air filter? ☐Yes ☐No ☐Don't know If yes, is it ☐a room unit or ☐on the control system?

Do you have a HEPA filter? ☐Yes ☐No ☐Don't know If yes, is it ☐a room unit or ☐on the control system?

Do you have air conditioning? ☐Yes ☐No ☐Don't know If yes, is it ☐a room unit or ☐on the control system?

Do you have a fireplace? ☐Yes ☐No ☐Don't know If yes, how often is it used? ____________________

Check rooms with wall-to-wall carpets: ☐bedroom ☐living room ☐TV room ☐Other: ____________________

What kind of bed do you sleep on: ☐single bed ☐bunk bed ☐waterbed

Stuffed animals in your bedroom: ☐Yes ☐No ☐If yes, in bed? ☐Yes ☐No

Do you have an allergen proof cover on your mattress? ☐Yes ☐No

How often is the inside of the pillow washed? ☐foam ☐feather ☐fiberfill ☐other: ______________________

Do you have any warm-blooded pets? ☐No ☐Yes If yes, check all that apply and the number that you have.

☐Cat (how many) _______ ☐Dog (how many) _______ ☐Bird (how many) _______ ☐Other

Do any pets stay or come indoors? ☐No ☐Yes If yes, where do pets sleep? ____________________________________

Does anyone smoke in your home? ☐No ☐Yes If yes, who smokes? ____

FOR ADULT

Your occupation: ____ Your employer: ____

Spouse's occupation: ___________________________________ Spouse's employer: _______________________________________

Have you ever worked in a factory, textile mill, grain mill, shipyard or mine or on a farm? ☐No ☐Yes

Have you ever had any job with high exposure to fumes, chemicals, dust or other noxious substances? ☐No ☐Yes

FOR CHILD

Father's occupation: ___________________________________ Father's employer: ____

Mother's occupation: ___________________________________ Mother's employer: _______________________________________

Is or was this child ever in daycare? ☐No ☐Past ☐Present

If Past or Present, at what age did he or she start? ___________ Number and ages of children there? __________________

Is or was this child ever in pre-school? ☐No ☐Past ☐Present

If Past or Present, at what age did he or she start? ___________ Number and ages of children there? __________________

If in school, current grade ____________________________

Does the child participate in any after school activities/sports? ____

WHO IS YOUR PRIMARY CARE DOCTOR?

Name ____ Specialty: ____

WHICH DOCTOR REFERRED YOU HERE?

Name: ____ Specialty: ____

ARE THERE OTHER DOCTORS WHO HAVE SEEN YOU OR ARE SEEING YOU?

Name: ____ Specialty: ____

Name: ____ Specialty: ____

Name: ____ Specialty: ____

IF ANY OTHER FAMILY MEMBERS ARE PATIENTS IN THE ALLERGY SECTION PLEASE LIST THEIR NAMES:

____ ____

Reviewed and discussed with patient and ___________________________________.

Name: ____

Date: __________________________ MRN: _____________