Briefly describe the reason for your visit (What is your main concern or symptom?): __________________________________________________________________________________________

### Review of Symptoms

<table>
<thead>
<tr>
<th>Symptom</th>
<th>None</th>
<th>Mild</th>
<th>Moderate</th>
<th>Severe</th>
<th>Currently have?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dark circles under eyes:</td>
<td></td>
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<tr>
<td>Itchy, watery eyes:</td>
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<tr>
<td>Red/burning eyes:</td>
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<tr>
<td>Swollen, puffy eyelids:</td>
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<tr>
<td>Ear infections:</td>
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<tr>
<td>Ear pain/pressure:</td>
<td></td>
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<tr>
<td>Ear popping:</td>
<td></td>
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<tr>
<td>Itchy ears:</td>
<td></td>
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<tr>
<td>Congestion/blocking nose:</td>
<td></td>
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<tr>
<td>Decreased sense of smell/taste:</td>
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<tr>
<td>Itchy nose:</td>
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<tr>
<td>Nasal/sinus drainage:</td>
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<tr>
<td>Nosebleeds:</td>
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<tr>
<td>Runny nose:</td>
<td></td>
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<tr>
<td>Sinus pressure/pain:</td>
<td></td>
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<tr>
<td>Sneezing:</td>
<td></td>
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</tr>
<tr>
<td>Snoring:</td>
<td></td>
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<tr>
<td>Sore throat:</td>
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<tr>
<td>Bad breath:</td>
<td></td>
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<tr>
<td>Hoarseness:</td>
<td></td>
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<tr>
<td>Postnasal/throat drainage:</td>
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<tr>
<td>Throat clearing:</td>
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</tr>
</tbody>
</table>

### Allergy Symptoms

- Sore throat:      
- Bad breath:       
- Hoarseness:       
- Postnasal/throat drainage:  
- Throat clearing:  

### Sinus History

- How many times have you been treated for a sinus infections with an antibiotic in the past year?  
  - None  
  - 1x  
  - 2x  
  - 3x or more  
  Which antibiotic helped most: ____________

- What is the color of your nasal drainage?  
  - Clear  
  - Brown  
  - White  
  - Green  
  - Yellow  
  - Blood-tinged  

- Have you ever had nasal polyps?  
  - Yes  
  - No  

- Have you ever had an x-ray or CT scan of your sinuses?  
  - Yes  
  - No  

- Performed when? ________________  
- Where? __________________________________________________________________________________________
Headaches?

- Yes
- No

If yes: What type?  
- sinus
- tension
- migraine

Location of headache:  
- frontal
- temple area
- back of head
- one sided

Other symptoms with headache? (ex. Nausea, vomiting, visual changes, dizziness, etc.) __________
_________________________________________________________________________________

Have you ever been diagnosed with asthma? 

- Yes
- No

- None
- Mild
- Moderate
- Severe
- Currently have?

Lung Symptoms

- Croup/laryngitis:
- Cough:
- Cough that wakes you at night:
- Cough productive of mucus:
- Cough with exercise:
- Chest congestion:
- Shortness of breath (SOB) at rest:
- SOB with exercise:
- SOB at night:
- Wheezing:

What trigger factors make your symptoms worse? (ie. exercise, cold air, infections, pets, etc.)
_______________________________________________________________________________________
_______________________________________________________________________________________

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/dates? ______________________________
_____________________________________________________________________________________________________________

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: __________________________________________
_____________________________________________________________________________________________________________

ADC Allergy • Asthma • Immunology • Respiratory

Name: ________________________________

Date: _____________________  MRN: ___________
What respiratory diagnosis (if any) have you been given by a physician?  (check all that apply)

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date when symptoms began</th>
<th>Diagnosis</th>
<th>Date when symptoms began</th>
</tr>
</thead>
<tbody>
<tr>
<td>COPD/Emphysema</td>
<td></td>
<td>Heart Failure</td>
<td></td>
</tr>
<tr>
<td>Asthma</td>
<td></td>
<td>Pneumonia</td>
<td></td>
</tr>
<tr>
<td>Asthma, exercise induced</td>
<td></td>
<td>Pulmonary fibrosis</td>
<td></td>
</tr>
<tr>
<td>Bronchitis</td>
<td></td>
<td>Tuberculosis</td>
<td></td>
</tr>
<tr>
<td>Bronchiectasis</td>
<td></td>
<td>Positive TB test</td>
<td></td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td></td>
<td>Interstitial disease</td>
<td></td>
</tr>
<tr>
<td>Sleep apnea</td>
<td></td>
<td>Vocal cord dysfunction</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

Asthma History: (If you do not have asthma skip this section)  Check the symptoms that most apply to you

Symptom frequency

- < 2 days/month
- < 2 days/week
- 2-6 days/week
- Daily

Do your symptoms go away completely after you use your inhaler?

- No
- Yes (which inhaler? ________________)

How often do you use extra inhaler treatments?

- < 2 days/month
- < 2 days/week
- 2-6 days/week
- Daily

Have you ever been admitted to hospital because of asthma?

- No
- Yes  If yes, how many in the last year? _________

Have you ever 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.

<table>
<thead>
<tr>
<th>Medication and Strength</th>
<th>How Much and How Often</th>
<th>Taken Daily?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Yes ❑ No</td>
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<td>Yes ❑ No</td>
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<td>Yes ❑ No</td>
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<td></td>
<td>Yes ❑ No</td>
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<tr>
<td></td>
<td></td>
<td>Yes ❑ No</td>
</tr>
</tbody>
</table>

What other allergy or asthma medicines have you tried in the past?

What other medical conditions have you been diagnosed with or are being treated for?  (eg. AIDS or HIV, Cancer, Diabetes, Epilepsy, Glaucoma, Heart disease, Hiatal hernia, High blood pressure, High cholesterol, Migraine headaches, Prostate disease, Stroke, Thyroid disease, etc.)

Past Medical History

List of hospitalizations:

<table>
<thead>
<tr>
<th>DATES OF HOSPITALIZATION</th>
<th>NAME OF HOSPITAL</th>
<th>REASON FOR HOSPITALIZATION</th>
</tr>
</thead>
<tbody>
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</table>

ADC Allergy ● Asthma ● Immunology ● Respiratory  Name: ____________________________

Date: ________________________  MRN: __________
Please list all surgical procedures and the dates they were done (including tonsillectomy, adenoidectomy, tubes in ears, etc.):

<table>
<thead>
<tr>
<th>PROCEDURE</th>
<th>DATE</th>
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</thead>
<tbody>
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</tbody>
</table>

Please list all known medication allergies:

<table>
<thead>
<tr>
<th>NAME OF MEDICINE</th>
<th>REACTION &amp; DATE OF REACTION</th>
</tr>
</thead>
<tbody>
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</tbody>
</table>

Smoking/Tobacco Use:  □ Never  □ Currently  □ Former
If current or former, what type of tobacco (chewing, cigarettes, cigar, etc)? _____________________________________________
At what age did you start using tobacco? ________ How much did/do you smoke or chew? ________ When did you quit? ________

Previous Tests Done
Check-off any previous testing you have had. Please give approximate dates and results.

<table>
<thead>
<tr>
<th>APPROXIMATE DATE</th>
<th>RESULT</th>
</tr>
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<tbody>
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</table>

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

Other 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 appetite, fatigue, cold intolerance, heat intolerance

Lymph Nodes: swelling, tenderness

Heart: chest pain, palpitations, swelling of ankles, inability to lie flat in bed

Intestinal tract: nausea, vomiting, heartburn, indigestion, trouble swallowing liquids or solids, 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

Neurologic: fainting spells, severe headaches, epilepsy (seizures), difficulty with memory, inability to concentrate

Provide an explanation for any symptoms that are particularly bothersome to you: _____________________________________________

ADC Allergy • Asthma • Immunology • Respiratory  
Name: _________________________________________  
Date: ____________________________  MRN: _________
Family History

<table>
<thead>
<tr>
<th></th>
<th>Father</th>
<th>Mother</th>
<th>Parent's Siblings</th>
<th>Grandparents</th>
<th>Patient's Children</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Seasonal nasal symptoms (hay fever)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Chronic nasal symptoms</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Sinusitis</td>
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<td>☐</td>
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<td>☐</td>
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<tr>
<td>Recurrent ear infections</td>
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<td>☐</td>
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<tr>
<td>Asthma</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Bronchitis (non-smoker)</td>
<td>☐</td>
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<tr>
<td>Eczema</td>
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<tr>
<td>Food allergy</td>
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<tr>
<td>Other:</td>
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</tbody>
</table>

For Adult: Age & gender of your children ________________________________

For Child: Age & gender of your child's siblings __________________________

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 had water damage before? ☐ Yes ☐ No

Type of heating and air conditioning in home: ☐ central air ☐ window unit

Do you have allergy air filters (electrostatic, HEPA, etc.)? ☐ Yes ☐ No ☐ Don't know

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

Do you have wall-to-wall carpet in your bedroom: ☐ Yes ☐ No

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

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

What type of pillow do you have? ☐ 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: ________________________________________

Have you ever worked in a factory, textile mill, grain mill, shipyard, 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: ______________________ Mother's occupation: ______________________

Is this child currently in daycare? ☐ No ☐ Yes If yes, how often? ________________ At what age did he/she start? ________________

Is this child currently in school? ☐ No ☐ Yes

If in school, current grade __________________________

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

ADC Allergy • Asthma • Immunology • Respiratory

Name: __________________________ MRN: _______________________

Date: __________________________
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 our Allergy Clinic, please list their names:
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________
_________________________________________________

Reviewed and discussed with patient and ___________________________.

Name: ___________________________  MRN: _____________
Date: _____________________________