NORTHEASTERN ASTHMA & ALLERGY, ASSOC., LLC

DATE: _____ PHYSICIAN:_____

PATIENT NAME:_____

AGE_____DATE OF BIRTH:_____SEX:_____

RACE_____

REASON FOR VISIT:_____

SOURCE OF REFERRAL:_____

LIST OF OTHER PHYSICIANS YOU SEE: _____

_____

PRESENTING COMPLAINT

1)_____

2)_____

3)_____

4)_____

HISTORY OF PRESENTING COMPLAINT

SEVERITY:_____

TIMING:_____

DURATION:_____

QUALITY:_____

CONTEXT:_____

MODIFYING FACTORS:_____

LOCATION:_____

ASSOCIATED SIGNS/SYMPTOMS:_____

OTHER:_____

PAST MEDICAL HISTORY

_____

_____

_____

PLEASE CIRCLE *YES* OR *NO* IF YOU HAVE ANY OF THE FOLLOWING MEDICAL PROBLEMS.

DIABETES……YES NO **GASTROINTESTIONAL PROBLEMS……..YES NO**

BLEEDING DISORDER……..YES NO **GENITOURINARY PROBLEM……YES NO**

CANCER……YES NO **CARDIAC PROBLEM……..YES NO**

STROKE……YES NO **INFECTIOUS DISEASE……..YES NO**

OCCUPATIONAL HISTORY

JOB TITLE AND DURATION	COMPANY AND LOCATION	EXPOSURES AND DURATION
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

JOB STATUS_____SOURCE OF INCOME_____

FAMILY HISTORY: CIRCLE APPROPRIATE AND LIST MEDICAL PROBLEMS

FATHER: ALIVE/DECEASED	MOTHER ALIVE/DECEASED	SIBLINGS
_____	_____	BROTHERS_____SISTERS_____
_____	_____	_____
_____	_____	_____

CHOICE OF HOSPITAL FOR ADMISSION_____

_____

ADVANCED DIRECTIVES_____

_____

POWER OF ATTORNEY_____

_____

MEDICINES:

Medicine	Route	Frequency	Duration
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ALLERGIES:

Drug/Agent	Reaction Type
_____	_____
_____	_____
_____	_____

Past Surgical History:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History:

Smoking: Age Started: _____Age ended: _____Average/day: _____

Alcohol: amount/day:_____ Other Drugs: _____ _Amount: _____

Exercise: _____

Marital Status: _____

People Living in Household: _____

Age of House/Building: _____

Exposure to chemicals and dusts outside of workplace: _____

Hobbies: _____

REVIEW OF SYSTEMS: PLEASE CIRCLE Yes or No if you have any of the following

1) **Constitutional**

Good General Health…..Yes or No

Recent Weight Change…Yes or No

Night Sweats/Fevers……Yes or No

2) Ears/Nose/Mouth/Throat

Nose Bleeds……Yes or No

Congestion,Stuffy Nose..Yes or No

Post Nasal Drip……..Yes or No

Sore Throat……..Yes or No

Voice Change……..Yes or No

Sinus Problems……..Yes or No

Hearing Loss or Tinnitus…Yes or No

Other

3) Respiratory

Cough of Blood……Yes or No

Shortness of Breath……..Yes or No

Wheezing……Yes or No

Dyspnea on exertion……Yes or No

Cough……..Yes or No

4) Cardiovascular

Chest Pain……Yes or No

Palpitations……Yes or No

Murmur……Yes or No

Swelling of Feet……Yes or No

5) Allergic/Immunologic

Indoor Allergies……..Yes or No

Seasonal Allergies…..Yes or No

Food Allergies……Yes or No

6) Gastrointestinal

Nausea/Vomiting…….Yes or No

GERD……..Yes or No

Abdominal Pain……Yes or No

Rectal Bleeding……..Yes or No

Black Tarry Stools…….Yes or No

7) GU

Blood in Urine……..Yes or No

Kidney Stones……..Yes or No

Sexual Problems……..Yes or No

8) Endocrine

Excessive Thirst/Urination Yes or No

Thyroid Disease……Yes or No

Excessive Hair Growth…….Yes or No

Excessive Eating……Yes or No

Feeling Cold/Hot……..Yes or No

9) Musculoskeletal

Muscle Pain……Yes or No

Joint Pain……..Yes or No

Stiffness/Swelling……..Yes or No

Difficulty Walking……..Yes or No

10) Eyes

Glaucoma……Yes or No

Blurred/Double Vision….Yes or No

Watery Eyes……Yes or No

11) Integumentry (Skin/Breast)

Rashes, Itching……Yes or No

Breast Lump……..Yes or No

Breast Pain/Discharge….Yes or No

12) Hematolgic/Lymphatic

Excessive Bleeding ……Yes or No

Enlarged Glands……Yes or No

Easy Bruising……Yes or No

Excessive Clotting…….Yes or No

13) Neurological

Frequent Headaches……..Yes or No

Convulsions/Seizures……..Yes or No

Numbness/Tingling……..Yes or No

Paralysis/Tremors……..Yes or No

14) Psychiatric

Depression……..Yes or No

Insomnia……..Yes or No

Anxiety……..Yes or No

PREVENTIVE PULMONARY MEDICINE

Smoking Cessation	_____	_____	_____
Osteoporosis	_____	_____	_____
Glucose	_____	_____	_____
PPD	_____	_____	_____
Pneumovax	_____	_____	_____
Flu Vaccine	_____	_____	_____

PATIENT STATEMENT: To the best of my knowledge, the above information is accurate and complete

Signed: _____ Date: _____

PHYSICIAN STATEMENT: I have reviewed the questionnaire with the patient.

Signed: _____ Date: _____