VALLEY ALLERGY AND ASTHMA CLINIC, LLC

Medical History Questionnaire

OFFICE USE ONLY		
T _____ Wt _____ Ht _____ BP _____ HR _____ Ox _____	V? Y N Date: _____ Talk? Y N Flu? Y N Date: _____ Beta Blocker? Y N Off Antihist? Y N How long? _____	Past VAAC pt? Personal: Y N Family: Y N Name(s): _____ _____ _____

Today's DATE: _____

Patient Name: _____

DOB: _____ **Age:** _____

Medications

What medications do you take on a daily or frequent basis? Please include all prescription and over-the-counter medications to include sprays, inhalers, and supplements.

Medication Name	Dose and Frequency	Indication/Start Date

Allergies to Medications

List any allergies to prescribed and/or over the counter medications that you have.

Medication Allergy	Type of Reaction	Reaction Date

Other Allergies (foods, specific skin products, latex, etc.)

Other Allergies, if any	Type of Reaction	Reaction Date

Main Reason for Visit (What brings you here?)

Please tell us the main reason you are here today and include any issues you would like to discuss with Dr. Arseneau.

_____

_____

_____

_____

Past Medical and Surgical History

Have you ever been diagnosed with any of the following? Please Circle.

Recurrent Infection	COPD/Emphysema	Migraines	Diabetes
Nasal Polyps	Heart Disease	Hypertension	Swelling (Angioedema)
GERD (reflux)	Thyroid Disease	Recurrent Hives	Cancer

Patient Name:_____ **DOB:** _____

Have you ever had an appointment with an allergist before? If yes, When? _____ Where? _____	YES	NO
Do you think you may have seasonal or year round allergies (hay fever)? a. If Yes, have you been skin tested before? YES / NO b. Have you been on allergy shots before? YES / NO c. What season is problematic for you? ____Spring ___Summer ____Fall ____Winter d. Do you have any of the following symptoms? ___stuffy nose ___sneezing ____itchy red eyes ____runny nose ___post nasal drainage e. What triggers your symptoms?_____ f. Have you noticed any of these things trigger your symptoms? ___perfumes ___cold or hot temperatures ___dust ___smoke g. When did your symptoms begin?_____ h. What medications have helped?_____ i. What medications have not helped? _____	YES	NO
a. Have you ever been diagnosed with eczema? b. Regardless of your answer to ***a.*** above, do you have other skin concerns? c. If yes to either, what do you apply to your skin and how many times daily? _____	YES YES	NO NO
a. Have you ever been diagnosed with asthma? b. Regardless of your answer to 3a, have you ever used inhalers? c. If yes to either, please mark all that apply below: ☐Last use of short acting "rescue" inhaler: _____ ☐Ever had a breathing test d. Regardless of your answers above, do you <u>regularly</u> have any of the following symptoms? Please mark all that apply. ☐Chest tightness ☐Cough ☐Shortness of breath ☐Wheezing	YES YES YES	NO NO NO
Have you ever had an adverse reaction to a bee, wasp, hornet, fire ant or mosquito? If yes, when and what happened? _____	YES	NO
Have you ever had an adverse reaction to food? If yes, please specify below the food, date when reaction happened and symptoms. Food 1_____ Date:_____ Symptoms _____ Food 2_____ Date:_____ Symptoms _____ Food 3_____ Date:_____ Symptoms _____	YES	NO
Have you ever had an adverse reaction to latex?	YES	NO
<u>For female patients age 12 to 49</u>: Are you or might you be pregnant?	YES	NO

Have you ever been hospitalized overnight for reasons other than surgery? If so, please list.

_____

_____

Have you ever had a surgery? If so, when and what type?

_____

_____

Patient Name:_____ **DOB:** _____

Family History

Does anyone in your family have or had any of the conditions below? Please circle.

Allergies	Mother	Father	Brother(s)	Sisters(s)
Asthma	Mother	Father	Brother(s)	Sisters(s)
Eczema	Mother	Father	Brother(s)	Sisters(s)
Food Allergy	Mother	Father	Brother(s)	Sisters(s)
Recurrent Swelling	Mother	Father	Brother(s)	Sisters(s)
Immune System Problems	Mother	Father	Brother(s)	Sisters(s)
Other:_____	Mother	Father	Brother(s)	Sisters(s)

Social History *NOTE: If patient is a child, please answer questions for adult caretakers.*

Do or did you ever smoke tobacco? YES NO

a. If yes, how much and how long? ____ pack(s)/day (or week) for ____ years
b. Quit date: _____
c. If patient is a child, is there exposure to second-hand smoke? YES NO
d. If adult, is there exposure to second-hand smoke? YES NO
e. Do or did you ever vape? YES NO
f. Do you use marijuana? YES NO

If yes, circle the method and timing of use: **Method:** Vape Smoke Edibles

Timing: Daily Weekly Monthly Occasionally **For:** _____ years.

What do you do most days of the week, and where? (e.g. public school, daycare, homemaker, office work, construction work, etc.)

_____

Have you ever spent more than two months of your life in an environment that could be considered hazardous to your lungs, such as chemical or fine particle dust exposure? Please specify. (e.g. mining, chemical plant, construction, auto mechanic, fire fighter)

_____

Environmental History

Do you have or are you around pets? If yes, please indicate how many animals (indoor & outdoor).

Cats ___ Dogs ___ Birds ___ Guinea Pigs ___ Rabbits ___ Horse ___ Other (specify) ___

Number of years lived in present home? _____

Review of Systems

Please circle problems you currently have or have frequently had in the past.

General:	Fever	Chills	Unintended Weight loss	
	Night sweats	Fatigue	Weight gain	
Eyes:	Itch	Pain	Excessive tears	Dryness
	Loss of Vision			
Ears/Nose/Throat:	Chronic nasal congestion	Chronic sinus infection	Frequent ear infection	Ringing in ear
	Ear tubes	Hearing loss	Dizzy spells	Snoring
	Sleep apnea	Frequent nose bleeds	Hoarseness	Frequent sore throat
	Trouble swallowing	Nasal polyps		
Lung and Chest:	Cough	Wheeze	Shortness of breath	Coughing up blood
	Coughing up phlegm			
Heart:	Chest pain	Palpitations	Irregular heartbeat	Swelling of ankles
Gastrointestinal:	Nausea	Vomiting	Abdominal pain	Diarrhea
	Constipation	Vomiting blood	Blood in stool	Heartburn
Skin:	Hives	Rash	Itching	Swelling
Musculoskeletal:	Joint pain	Muscle pain or cramps	Joint swelling	
Genitourinary:	Pain/burning urination	Frequent urination	Blood in urine	
Mental Health:	Anxiety	Depression		
Neuro:	Headaches	Seizures	Numbness or tingling	