

MEDICAL HISTORY



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Name: _____ Age: _____ Date of Birth: ____/____/____

Primary Care Physician: _____ Referring Physician: _____

Reason for today's visit: _____

Have we seen another member of the family?

Yes No

If yes, please list name(s):

Current Medications:

Medication Allergies:

None

Penicillin:

Reaction: _____

Other: _____

Reaction: _____

Medical History:

Hay fever Symptoms: Yes No; If yes which seasons?

Spring Summer Fall Winter

Food Allergies: Yes No

If yes, to which foods: _____

Have you ever had an allergy skin test?

No Yes; When? _____

Have you ever had allergy shots?

No Yes; When? _____

Breathing Issues:

With Exercise: Yes No

With Colds: Yes No

Bee Sting Allergy:

No Yes; Reaction _____

Asthma: Yes No

Past Surgical History:

Eczema: Yes No

Eosinophilic Esophagitis: Yes No

Latex Allergy: Yes No;

Reaction _____

Pets:

Other Medical History: _____

Symptoms to Dogs: Yes No

Symptoms to Cats: Yes No

Other: _____

Family History of Allergies or Asthma:

Bedroom:

No

Carpet Yes No

Yes; Relationship _____

Humidifier Yes No

Yes; Relationship _____

Dust mite covers Yes No

Stuffed animals in room Yes No

REVIEW OF SYSTEMS:



**Allergy, Asthma,
& Sinus of NOVA**

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(Check any that apply)

General

- weight gain/loss
- poor sleep
- fatigue
- fever
- headache
- depression

Eyes, ears, nose, throat

- blurred vision
- other change in vision
- history of glaucoma or cataracts
- loss of hearing
- ringing in ears
- sinus infection
- sinus headaches
- congestion
- post nasal drip
- mucus
- hoarseness

Skin

- itching
- rash or skin sensitivity
- easy bruising
- change in moles

Pulmonary/lungs

- shortness of breath
- persistent cough
- coughing up blood
- asthma or wheezing
- coughing over 3 months
- bronchitis
- pneumonia

Cardiovascular

- chest pain
- history of angina or heart attack
- history of high blood pressure
- history of irregular heart beat
- history of poor circulation

Gastrointestinal

- poor appetite
- abdominal pain
- indigestion
- trouble swallowing
- diarrhea
- constipation
- change in bowel habits
- nausea or vomiting
- rectal bleeding or blood in stools
- history of liver disease or abnormal liver tests

Endocrine

- diabetes
- thyroid problems
- autoimmune disease
- excessive thirst
- cold/heat intolerance

Neurologic

- history of stroke
- seizures
- blackouts or loss of consciousness

Musculoskeletal

- swelling of ankles or legs
pain, weakness or numbness in:
 - arms or hands
 - back or hips
 - legs or feet
 - neck or shoulders

Genitourinary

- frequent or painful urination
- blood in urine

Psychiatric

- anxiety
- depression