MEDICAL HISTORY

Allergy, Asthma, & Sinus of NOVA
Adhuna Mathuria, MD
24600 Millstream Drive Suite 360
Aldie, VA 20105
703-327-3300

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: _____

Breathing Issues:

With Exercise: □ Yes □ No

With Colds: □ Yes □ No

Asthma: □ Yes □ No

Eczema: □ Yes □ No

Eosinophilic Esophagitis: □ Yes □ No

Latex Allergy: □ Yes □ No;

Reaction_____

Other Medical History: _____

_____

_____

Have you ever had an allergy skin test?

□ No □ Yes; When? _____

Have you ever had allergy shots?

□ No □ Yes; When? _____

Bee Sting Allergy:

□ No □ Yes; Reaction _____

Past Surgical History:

_____

_____

_____

Pets:

Symptoms to Dogs: □ Yes □ No

Symptoms to Cats: □ Yes □ No

Other: _____

Bedroom:

Carpet	□ Yes □ No
Humidifier	□ Yes □ No
Dust mite covers	□ Yes □ No
Stuffed animals in room	□ Yes □ No

Family History of Allergies or Asthma:

□ No

□ Yes; Relationship _____

□ Yes; Relationship _____

REVIEW OF SYSTEMS:

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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 of painful urination
- ☐ blood in urine

Psychiatric
- ☐ anxiety
- ☐ depression