Allergy & Sinus Center

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DATE

NAME_____ AGE D.O.B.
LAST FIRST

ADDRESS_____ REFERRED BY:
STREET

_____ MARITAL STATUS: S M W D
CITY STATE

PHONE_____ BUSINESS PHONE_____ SOC. SEC. #

CHIEF COMPLAINT:

PRESENT ILLNESS (Dr. Ein will fill this in.)

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____**A.**

PRESENT ILLNESS & ALLERGY HISTORY : Do you experience the following?

EYES: [ ] Red or swollen eyelids [ ] Itching [ ] Redness [ ] Swelling [ ] Tearing
[ ] Sensitive to light [ ] Burning [ ] Discharge [ ] Dark circles under eyes
[ ] Double Vision

EARS: [ ] Frequent Infections [ ] Itching [ ] Drainage [ ] Fullness [ ] Popping
[ ] Changes in hearing [ ] pain

NOSE: [ ] Itching [ ] Sneezing [ ] Discharge (clear, yellow, green)
[ ] Stuffiness [ ] Headache (location)_____ [ ] Can not smell
[ ] Mouth breathing [ ] Constant nose rubbing [ ] Bleeding

THROAT: [ ] Post-nasal drip [ ] Soreness [ ] Itchy throat [ ] Mucus in a.m.
[ ] Hoarseness [ ] No taste [ ] Tonsils removed [ ] Adenoids removed

NAME_____

CHEST: [ ] Cough [ ] Wheezing [ ] Pain [ ] Night-time cough

[ ] Phlegm (amount_____color___ ____) [ ] Shortness of breath (at rest____ with exertion____)

[ ] Palpitations

ABDOMEN: [ ] Heartburn [ ] Diarrhea [ ] Milk intolerance [ ] Acid regurgitation

[ ] Nausea [ ] Vomiting [ ] Changes in bowel movements

URINARY: [ ] Pain or burning [ ] Frequency [ ] Bleeding [ ] Infections

ENDOCRINE: [ ] Diabetes [ ] Thyroid Disease

HEMO/LYMPH [ ] Swollen glands [ ] Anemia [ ] Easy bruising

INFECTIOUS [ ] Fever [ ] Chills [ ] Night Sweats

MUSCULOSKELETAL [ ] Pain [ ] Joint swelling [ ] Loss of mobility

SKIN: [ ] Itchy patches [ ] Dry skin [ ] Eczema (scaly crusts) [ ] Hives

[ ] Swelling (location_____)

PSYCHIATRIC [ ] Depression [ ] Anxiety [ ] Other:_____

TRIGGERS: Which of the following causes your symptoms?

ENVIRONMENTAL

[ ] All year around [ ] Spring [ ] Summer [ ] Fall [ ] Winter (specify months)

[ ] Animals (cat, dog, etc) [ ] Dust [ ] Fumes _____ [ ] Temperature Changes

[ ] After physical activity [ ]Nighttime [ ] Menses (period) [ ] After meals [ ] lying down

[ ] Common cold [ ] Weekdays [ ] Weekends [ ] Cold Air [ ] Draft

[ ] Indoors [ ] Outdoors [ ] Home [ ] Office [ ] Basement

[ ] Beach houses [ ] Muggy weather

FOODS

[ ] Cheese [ ] Milk [ ] Chocolate [ ] Melon [ ] Mushrooms [ ] Nuts (peanut butter)

[ ] Citrus fruits [ ] Bananas [ ] Beer [ ] Wine [ ] Shellfish [ ] Other seafood [ ] soy [ ] egg [ ]wheat [ ] other

PHYSICAL AGENTS AND HABITS

[ ] Perfumes [ ] Cold [ ] Heat [ ] Cosmetics [ ] Chemicals

[ ] Hair Spray [ ] Insecticides [ ] Paints [ ] Newspapers [ ] Cigarettes [ ] Stuffed animals

[ ] Central Heating [ ] Air conditioning [ ] Cigarette/cigar/pipe smoke **

** Who in the family smokes?: [ ] Patient [ ] Spouse [ ] Mother [ ] Father [ ] Sibling [ ] Other_____

If you smoke, how many cigarettes daily?_____ What effect does it have?_____

1. Have the allergic symptoms become [ ] Worse or [ ] Better with time?
2. How often do the symptoms occur? Asthma, Wheezing: [ ] Once a day [ ] Once a week [ ] Once a month [ ] Once a year

Hives: [ ] Once daily [ ] More then once daily [ ] Once a week [ ] Once a month [ ] Once a year

Nasal and/or Sinus [ ] Once a day [ ] Once a week [ ] Once a month [ ] Once a year

NAME

NAME_____

B. PREVIOUS ALLERGY TESTING AND TREATMENT

Have you ever had any of the following:

[ ] Allergy testing, by Dr._____ Where:_____ [ ] Results:_____

[ ] Allergy shots?_____ For how long?_____ Symptoms improved?_____

Medications tried:

Nasal Sprays: [ ] Vancenase [ ] Beconase [ ] Nasocort [ ] Nasalide [ ] Nasonex [ ] Rhinocort [ ] Flonase [ ] Nasalcrom

Inhalers: [ ] Proventil [ ] Ventolin [ ] Maxair [ ] Alupent [ ] Severent [ ] Flovent [ ] Azmacort [ ]Vanceril

[ ] Beclovent [ ] Aerobid [ ] Tilade [ ] Intal [ ]Advair

Oral Medications: [ ] Allegra [ ] Allegra D [ ] Claritin [ ] Claritin D [ ] Zyrtec [ ] Zyrtec-D [ ] Sudafed

[ ] Exgest [ ] Duravent [ ] Deconsal [ ] Dura-Tuss [ ] Theophylline [ ] Theo Dur

[ ] Uniphyl [ ] Prednisone [ ] Medrol [ ] Singulair [ ] Accolate

[ ] Other medications tried:_____

CURRENT MEDICATIONS:

_____

_____

PAST MEDICAL HISTORY:

HOSPITALIZATIONS:_____

ER VISITS:_____

SURGERIES:_____

SERIOUS ILLNESSES OR TRAUMA:_____

LATEX SENSITIVITY:_____

INSECT STING REACTIONS:_____

LAST CHEST X-RAY_____LAST PULMONARY FUNCTION_____ ANY ENT EVALUATION?

SINUS CT SCAN OR X-RAY?_____

DRUG ALLERGIES AND REACTIONS:

_____

_____

_____

FAMILY HISTORY OF ALLERGIES :

MOTHER_____FATHER_____

SISTER(s)_____ BROTHER(s)_____

CHILDREN

_____

SOCIAL HISTORY:

MARITAL STATUS: YEARS OF EDUCATION:

STATUS:

CURRENT OCCUPATION: HOBBIES

OCCUPATIONAL EXPOSURES/GEOGRAPHY:

SMOKING: CURRENT: PAST:

NAME_____

ENVIRONMENTAL HISTORY:

HOME:

HOUSE/APT: AGE OF BUILDING):

LENGTH OF OCCUPANCY:

AIR CONDITION (CENTRAL/WINDOW): HUMIDIFIER (CENTRAL/SEPARATE UNITS):

BASEMENT (DAMP, MUSTY, SEEPAGE, FLOODING):

BEDROOM (BOXSPRING/MATTRESS, WATERBED)**:** : FLOOR STYLE (WOOD, CARPET(

PILLOW (FEATHER/NON-FEATHER): COMFORTER (FEATHER/NON-FEATHER):

Is there a lot of "stuff" in the room? Frequency of cleaning:

PETS: DO THEY HAVE ACCESS TO BEDROOM?:

DO YOU HAVE ROACHES?

WORK:

Are you better [ ] worse [ ] or the same [ ] at work as at home? Do you have a separate office?

How old is your building? Do your co-workers complain of the air quality?

What kind of work do you do? Are you exposed to chemical fumes?

How often is the work place cleaned?

On a scale of 0 to 10 (10 being total incapacity), how much do your symptoms interfere with yopur ability to function?

PHYSICAL EXAM: P BP RESP TEMP HT WGT

GENERAL APPEARANCE DATE

EYES: CONJUNCTIVAE: SCLERAE: LIDS:

NOSE: MUCOSA: SEPTUM: TURBINATES:

SINUS TENDERNESS OROPHARYNX: TEETH & GUMS: PN DRIP

EARS: TM'S: CANALS:

NECK: THYROID (ENL/Tend/MASS)

LYMPHATICS: NECK AXILLA GROIN EPITROCHLEAR

CHEST: PERCUSSION RALES WHEEZING RHONCHI

CVS/HEART: PMI: SOUNDS

ABDOMEN: SHAPE TENDERNESS MASSES

LIVER SPLEEN

SKIN: RASH LESION OTHER

FLEXURAL ECZEMA:

EXTREMITIES: INSPECTION EDEMA PULSES

NEURO/PSYCH: ORIENTATION MOOD &AFFECT

DIAGNOSIS	PLAN
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

FOLLOW UP: