NAME: ______________________ **ACCT #** ____________

Chief Complaint (Reason for coming in):

Check where applicable:

Nose/Ears/Eyes/Throat Symptoms

First noticed: ____________

- ☐ Sneezing
- ☐ Runny Nose
- ☐ Nasal Congestion
- ☐ Nose Bleeding
- ☐ Loss of Smell
- ☐ Nasal Polyps
- ☐ Post Nasal Drainage
- ☐ Frequent Sore Throat
- ☐ Cough
- ☐ Frequent Respiratory Infections
- ☐ Earaches
- ☐ Ear Infections
- ☐ Hearing Loss
- ☐ Vertigo (Dizziness)
- ☐ Itchy, Watery Eyes

Worst Season: ____________

Skin/Eczema

- ☐ Rash
  - ☐ *Red*
  - ☐ *Swollen (raised)*
  - ☐ *Blisters (fluid filled)*
  - ☐ *Itchy*
  - ☐ *Scaly, dry*
  - ☐ *Infection*

Location on Body: ____________

Any Known Cause(s): ____________

Headache Symptoms

First noticed: ____________

- ☐ Sharp ☐ Pressure
- ☐ Dull ☐ Vise-like
- ☐ ____________

Location: ____________

Frequency: ____________

Time Headaches Worse: ____________

Any Known Cause(s): ____________

____

____

Treatment(s) Tried: ____________

____

Associated Symptoms such as

Sinusitis: ____________

Hives and/or Swelling

- ☐ Hives; Location: ____________
- ☐ Swelling; Location: ____________

First Noticed: ____________

____

____

Duration: ____________

____

____

Associated Symptoms: ____________

____

____

Chest Symptoms

First noticed: ____________

- ☐ Cough

  Sputum Color: ____________
- ☐ Wheeze
- ☐ Tight Chest
- ☐ Attacks
  - ☐ Night ☐ Daytime ☐ Work

Frequency of attacks: ____________

____

Last Attack ____________

- ☐ Bronchitis

Worst Season: ____________

Insect Allergy

When stung or bitten ____________

Insect ____________

Reaction(s): ____________

____

Treatment: ____________

____

Latex Allergy

- ☐ Occupation related
- ☐ Contact Dermatitis
- ☐ Hives
- ☐ Wheeze
- ☐ Other: ____________

____

Precipitating Factors: ***(Check if symptoms are worsened or affected by)***

- ☐ Weather change
- ☐ Rainy days
- ☐ Foggy days
- ☐ Fumes

  (Insecticides, chemicals, tobacco smoke)
- ☐ Physical exertion
- ☐ Musty odors
- ☐ Perfume or cosmetics
- ☐ House cleaning, moving
- ☐ House dust
- ☐ Mowing the lawn
- ☐ Infection
- ☐ Change of locale
- ☐ Newsprint
- ☐ Change in temperature
- ☐ Being around animals

  What type? ____________
- ☐ Playing (sitting) on grass
- ☐ Emotional stress (worries, excitement, etc.)
- ☐ Other: ____________

Medications

Allergy Medications (List all past and current medication given for allergy and state which ones are helpful)

List Other Current (non-allergy medications)

NAME: ______________________ **ACCT #** ____________

REVIEW oF SYSTEMS

Please check all items that apply and explain briefly

General Health: ☐ Good ☐ Bad ______________________

Constitutional: (General Symptoms) ☐ Fever ☐ Weight Loss ☐ Weight Gain ☐ Night Sweats
☐ Weakness ☐ Fatigue ☐ **None** ☐ Other: ______________________

Eyes: ☐ Poor Vision ☐ Cataracts ☐ Glaucoma ☐ Glasses ☐ Contacts (Type: ____________)
☐ **None** ☐ Other: ______________________

Ear, Nose, Throat and Mouth: (Not noted in allergy history)
☐ Pain ☐ Drainage ☐ Hearing Loss ☐ Vertigo (dizziness) ☐ or Tinnitus (ringing) ☐ Sore Mouth
☐ Dental problem ☐ **None** (other than allergy) ☐ Other: ______________________

Cardiovascular: (Heart and blood vessels)
☐ High Blood Pressure ☐ Heart Attack ☐ Palpitations (and other arrhythmias) ☐ Heart Murmur
☐ Phlebitis ☐ **None** ☐ Other: ______________________

Respiratory: (Covered in Allergy Section)

Gastrointestinal: ☐ Peptic Ulcer ☐ Reflux ☐ Hepatitis ☐ Frequent Vomiting ☐ Abdominal Pain
☐ Frequent Diarrhea ☐ Loss of Appetite ☐ Chronic Constipation ☐ Bleeding ☐ **None**
☐ Other: ______________________

Genitourinary: ☐ Frequent Urination ☐ Dysuria (pain) ☐ Hematuria ☐ Nocturia (frequent night time urination)
☐ Recurrent Infection ☐ Sexual Dysfunction ☐ Kidney Stones ☐ Menstrual Problems ☐ Prostate Problems
☐ **None** ☐ Other: ______________________

Muscularskeletal: ☐ Joint Pain ☐ Muscle Pain ☐ Weakness ☐ **None** ☐ Other: ____________

Skin: (Covered in Allergy Section)

Neurological: ☐ Fainting ☐ Seizures ☐ Paralysis ☐ Headaches (other than sinus)
☐ **None** ☐ Other: ______________________

Psychiatric: ☐ Depression ☐ Anxiety ☐ Insomnia ☐ Abnormal Fears ☐ Mental Breakdown
☐ **None** ☐ Other: ______________________

Endocrine: ☐ Thyroid Dysfunction ☐ Diabetes ☐ Adrenal Dysfunction ☐ **None** ☐ Other: ____________

Hematologic/Lymphatic: ☐ Anemia ☐ Bleeding Problems ☐ Bloodborne infection: Hepatitis B/HIV
☐ **None** ☐ Other: ______________________

Cancer: ☐ Type: ______________________ ☐ **None**

Allergy/Immunology: (See Allergy other section) ☐ Immunodeficiency ____________

NAME: ______________________ **ACCOUNT NO.:** ______________________

Allergy History:

Previous allergy tests: ☐ Yes ☐ No If so, when? ____________ By Whom? ____________

Where Allergy injections started? ____________ How long were you on them? ____________

Did they help you? ____________

Medication allergy or intollerance (name drug and briefly describe reactions)

Food allergy (name food and briefly describe reactions)

Contact allergy (poison ivy, cosmetics, leather, metal, etc)

Environmental History:

List other places where you lived: ____________

How long have you lived in your present home? ____________

Location (city, farm, etc) ____________

Type of heater/air conditioner ____________

Pets: Indoor ____________ How long have you had it? ____________

Outdoor ____________ How long have you had it? ____________

Pillow Type ____________ With or Without Plastic Cover: ____________

Mattress Type ____________ With or Without Plastic Cover: ____________

Blanket Type ____________ How Old is it? ____________

Carpet Type ____________ Rug Type: ____________

Draperies Type: ____________ Indoor Plants? ____________

Smoker(s) ☐ Yes ☐ No ☐ In Home ☐ Work Stuffed toys in bedroom? ____________

Occupational Habits and Hobbies:

What type of Work? ____________

Do you smoke? ____________ How Long? ____________ How many a day? ____________

Did you smoke in the past? ____________ How Long? ____________ When did you stop? ____________

Do you drink alcohol? ____________ How Often? ____________

Do you use non-medicinal (recreation) drugs? ____________

Past Medical History: (List previous illnesses and hospitalizations; surgeries and Emergency Room visits)

Family History: (Please check if present)

Illness	Father	Mother	Brother	Sister	Children	Other
Asthma						
Hay Fever						
Sinus Problems						
Hives or Swelling						
Eczema						
Drug Allergy						
Sinus Headaches						
Migraine Headaches						
Diabetes						
Rheumatic/autoimmune						
Cancer						
Immunodeficiency						

NAME: ______________________ **ACCOUNT NO.:** ______________________

Additional History:

1-5	PF
6-11	EPF
12	D
ALL	COMP

Physical Examination: (**0**= negative or normal; **X**= abnormal or present; **NE**=not examined)

BP: ________ P: ________ Resp: ________ Temp: ________ Ht: ________ Wt. ________
General Appearance: ________
Allergic Facies ________ Allergic Shiners ________ Horizontal Nasal Crease ________ Allergic Salute ________
Eyes: Conjunctiva: ________
Nose: Mucosa: ________ Mucus ________
Ederna: ________ Polyps ________
Septum: ________ Turbinates: ________
Oral Cavity: ________ Pharynx ________
Teeth & Gums ________ PN Drip: ________
Ears: TM's: ________ Canals: ________
TMJ ________ Face/Sinus Tenderness ________
Neck: ________ Thyroid (Enl/Tend/Mass) ________
Lymphatics: Neck: ________ Axilla ________ Groin ________
CVS: Heart (Snd/M) ________ PV (Observ/palp) ________
Abdomen: Mass: ________ Tenderness: ________ Liver: ________ Spleen: ________
Chest: Ventilation: ________ ABN Sounds: ________
Wheezing: ________
Rales: ________ Rhonchi: ________
Resp. Effort (Retr/Accumuse/Diaph) ________
Skin: Rash: ________ Lesion: ________ Other: ________
Eczema: ________ Flexural: ________ Other: ________
Extremities: Inspection ________ Palpation: ________
Neuro/Psych: Orientation: ________ Mood & Effect: ________

Description of Abnormal Fidnings:

Impression:

Orders:

Frederick F. Herman, MD