**Name:** ______________________ **DOB**________ **Referred By: Dr.** ________________ **TCI #** __________

<u>FILL OUT</u> *whatever is **applicable or write N/A** & **<u>CHECK or CIRCLE</u> all that applies***



**<u>Current Medications</u> (list names only):** ______________________________________________

______________________________________________

______________________________________________

______________________________________________

**<u>Allergy</u> (list known allergies):** ______________________________________________

______________________________________________

______________________________________________

**<u>Past Medical History</u> (List major current and previous illnesses):** ______________________

______________________________________________

______________________________________________

**<u>HOSPITALIZATIONS</u>** for Asthma Flare up, Allergic Reactions, ______________________

**<u>ICU ADMISSIONS</u> for** <u>Asthma</u> Flare up or <u>Allergic Reactions</u>: ______________________

**<u>SURGICAL HISTORY</u>:** ______________________________________________

**<u>SOCIAL HISTORY</u>:** Smoking: Current/ previous __________ packs/day for ______ years, since __________ till ______

Environmental exposure: Cat, dog, other animals ______________; molds ______________________

Carpet in the bedroom, living room, ______________; ______________________________

______________________________________________

**<u>Review of Other Systems</u>**: *check all that applies*

***General***: Fatigue, fever

***Cardio-Vascular***: Palpitations,

***Hematological***: Swollen lymph nodes, anemia, bleeding tendency,

***Neurogical***: Headaches,

***Psychiatric***: Anxiety, depression, mood swings, __________

***Urinary***: Blood in urine

***Musculo-Skeletal***: Muscle pain, joint pain, ______________

**<u>LOCATION- EAR, NOSE, & THROAT</u>: Previous diagnosis: Hay fever, sinusitis, allergies,**

**Symptoms** - Nasal congestion, runny nose, sneezing, nasal itching, itchy scratchy throat, ______________

**Duration or Date of onset (approximate):** Greater than 10 years, 5-10 years, 1-5 years, ______________

**Timing**: Year around; seasonal exacerbation in spring, summer, fall, and/or winter; ______________

**Context: triggered by** - pollens, molds, dust, cat, dog, infections, cigarette smoke, weather changes, __________

**Severity**: symptoms/conditions – mild, moderate, severe, getting worse, variable, Controlled with Rx __________

Impact on **QUALITY of life**: None, affects sleep, affects work and/or school, impairs concentration, __________

**Modifying factors**: Response to current Rx – good/partial or limited; Rx not helping ______________

Previous treatments ______________________________ Previous allergy test ______________

**<u>SINUS</u> Symptoms:** chronic postnasal drainage, Persistent sinus congestion or fullness, sinus pressure/headaches,

Sinus Infections: ______ x per year, going on for ________ years. sinus x-ray/CT scan ______________

Treatments: Sinus rinse, Mucinex/guaifenesin, decongestants __________ **Sinus/Nose Surgery** __________

**<u>EYE</u>: current/active diagnosis:** Conjunctivitis, Dry Eyes, Glaucoma, ________ **duration or date of onset:** ________

**Symptoms:** *Itching, watering, redness, dryness, gritty feeling in the eyes,* ______________________

**Duration or Date of onset (approximate):** Greater than 10 years, 5-10 years, 1-5 years, ______________

**Timing**: Year around; seasonal exacerbation in spring, summer, fall, and/or winter; ______________

**Context: triggered by** - pollens, molds, dust, cat, dog, infections, cigarette smoke, weather changes, __________

**Modifying factors**: Response to current Rx: good/partial or limited ______________________

**Name:** ______________________ **DOB**_______ **TCI #** ______________ **Page 2**

**LOCATION- LUNGS/CHEST:** previous diagnosis: Asthma, COPD, Emphysema, ______________________
**Symptoms:** *acute/chronic/recurrent* - Cough, Wheezing, Shortness of Breath, Chest tightness, ______________
**Duration or Date of onset (approximate):** Greater than 10 years, 5-10 years, 1-5 years, ______________
**Timing:** Year around; seasonal exacerbation in spring, summer, fall, and/or winter; worse during nighttime _______
**Context: triggered by** - pollens, molds, dust, cat, dog, infections, cigarette smoke, weather changes, sports, _______
**Severity:** symptoms/conditions – mild, moderate, severe, getting worse, variable, Controlled with Rx ___________
**Rescue Rx use:** _____ x per day / week/ month; **pre-sports** inhaler: no / yes. **Night time asthma:** _____ x per wk___
**Steroid Courses or Injections:** no /yes____ x past year. **ER/Urgent Care visits for Asthma** flare up: no/ yes______
Impact on **QUALITY of life:** None, affects sleep, impairs physical activity, missed work and/or school: _____ days x year
**Modifying factors:** Response to current Rx – good/partial or limited; Rx not helping ______________________
Pulmonary consultation: no/ yes by Dr. ___________ PFTs: no / yes _______ Chest x-ray or CT scan: no/ yes ______

**LOCATION - SKIN:** scalp, eyelids, face, neck, chest, abdomen, back, buttocks, upper arms, forearms, hands, Palms, fingers, thighs, legs, feet, creases of elbows/wrists/knees/ankles, ______________________
**Symptoms:** *acute/chronic/recurrent* -skin itching, rashes, dry skin, hives, swellings soft eyes/lips/tongue/__________
**Duration or Date of onset (approximate):** Greater than 10 years, 5-10 years, 1-5 years, ______________
**Timing:** Year around; seasonal exacerbation in spring, summer, fall, and/or winter; worse during nighttime _______
**Context: triggered/exacerbated by** - dryness, sweating, hot humid weather, certain foods ______________
**Severity:** symptoms/conditions – mild, moderate, severe, getting worse, variable, Controlled with Rx ___________
Impact on **QUALITY of life:** None, affects sleep, affects work and/or school, impairs physical activity, ___________
**Modifying factors:** Response to current Rx – good/partial or limited; ________ Steroid (injection or oral): no/yes ____
Dermatology consultation: no/ yes by Dr. ___________ Skin Biopsy: no / yes ______________________

**LOCATION- Gastrointestinal:** previous diagnosis – GERD, Eosinophilic Esophagitis (EoE), ______________
**Symptoms:** *acute/chronic/recurrent* -heartburn, acid reflux, recurrent food impaction, ______________
**Duration or Date of onset (approximate):** Greater than 10 years, 5-10 years, 1-5 years, ______________
**Timing:** worse during nighttime/ early morning / after meals / ______________________
**Context: triggered by** - certain foods ______________________
**Severity:** symptoms/conditions – mild, moderate, severe, getting worse, variable, Controlled with Rx ___________
**Modifying factors:** Response to current Rx – good/partial or limited; Rx not helping ______________
Previous treatments ______________________ Previous GI consultation: no/ yes ______________
LABS: no/ yes _________ GI endoscopy: no/yes __________ Biopsy: no/ yes _________ other tests __________

**FOOD REACTIONS (known or suspected):** Milk/Dairy: ______________ Egg: ______________
Wheat/Gluten______________ Other Grains: ______________________
Peanuts ______________ Tree Nuts - almond, cashew, pistachio, hazelnut, pecan, walnut, ___________
Shellfish-crab, lobster, shrimp, clam, oyster, scallop, ______________ Fishes: ______________
______________________________________________

**IMMUNOLOGICAL:** Chronic, recurrent, unusual, or severe infections: no/yes ______________________
**diagnosis:** Immunodeficiency, ______________________ **Duration or date of onset:** ___________
**Severity/course:** stable; controlled with medications; partially controlled; getting worse ______________
Treatments: Antibiotic courses x _______ per year; ______________________
Immunoglobulin therapy: no/ yes ______________________ Previous consultations: ___________
LABS: no / yes ______________________ X Rays/ CT Scans: no/ yes ______________
other test ______________________________________________