VALLEY ALLERGY AND ASTHMA CLINIC, LLC

Medical History Questionnaire **DATE _____**

Patient Name:_____ **DOB: _____**

Medications

What medications do you take on a daily or frequent basis? Please include all prescription and non-prescription medications with doses if known, as well as pills, sprays, inhalers, and supplements.

Name	Dose	Indication/Start Date

Allergies

List any allergies to medications that you have.

Allergy	Type of Reaction	Reaction Date

Main Reason for Visit (Chief Complaint)

Please tell us the main reason you are here today and include any issues you would like to discuss with Dr. Arseneau.

Past Medical and Surgical History

Have you ever been diagnosed with any of the following? Please Circle.

Recurrent Infection	Emphysema	Migraines	Diabetes
Nasal Polyps	Heart Disease	Hypertension	Swelling (Angioedema)
GERD	Thyroid Disease	Recurrent Hives	Cancer

Patient Name:_____ **DOB:** _____

Did you get a flu shot for this season?	YES	NO
Do you think you may have seasonal or year round allergies (hay fever)? a. If Yes, have you been skin tested before? YES / NO b. Have you been on allergy shots before? YES / NO c. What season is problematic for you? ___Spring ___Summer ___Fall ___Winter d. Do you have any of the following symptoms? ___stuffy nose ___sneezing ___itchy red eyes ___runny nose ___post nasal drainage e. What triggers your symptoms?_____ f. Have you noticed any of these things trigger your symptoms? ___perfumes ___cold or hot temperatures ___dust ___smoke g. When did your symptoms begin?_____ h. What medications have helped?_____ i. What medication have not helped? _____	YES	NO
Have you ever been diagnosed with atopic dermatitis (eczema)? a. If yes, how many times per day do you apply moisturizers? _____	YES	NO
Do you have asthma or any of the following? ___cough ___trouble breathing ___wheezing ___chest tightness If you have been diagnosed with asthma: a. When were you diagnosed? _____ b. Have you ever been to the ER or hospitalized because of your Asthma YES / NO c. Do you have an asthma action plan? YES / NO d. Have you attended asthma education classes? YES / NO	YES	NO
Have you ever had an adverse reaction to a bee, wasp, hornet, fire ant or mosquito? If yes, when and what happened? _____	YES	NO
Have you ever had an adverse reaction to food? If yes, please specify below the food, date when reaction happened and symptoms. Food 1_____ Date:_____ Symptoms _____ Food 2_____ Date:_____ Symptoms _____ Food 3_____ Date:_____ Symptoms _____	YES	NO
Have you ever had an adverse reaction or allergy to latex?	YES	NO
Are you or may you be pregnant?	YES	NO

Have you ever been hospitalized overnight for reasons other than surgery? If so, please list.

Have you ever had a surgery? If so, when and what type?

Patient Name:_____ **DOB:** _____

If patient is a child, was the child born premature? YES / NO

Family History

Does anyone in your close family have or had any of the conditions below? please circle

Allergies	Mother	Father	Brother(s)	Sisters(s)	Other_____
Asthma	Mother	Father	Brother(s)	Sisters(s)	Other_____
Eczema	Mother	Father	Brother(s)	Sisters(s)	Other_____
Food Allergy	Mother	Father	Brother(s)	Sisters(s)	Other_____
Cancer	Mother	Father	Brother(s)	Sisters(s)	Other_____
Thyroid Disease	Mother	Father	Brother(s)	Sisters(s)	Other_____
Autoimmune Disease	Mother	Father	Brother(s)	Sisters(s)	Other_____
Recurrent Swelling	Mother	Father	Brother(s)	Sisters(s)	Other_____
Immune System Problems	Mother	Father	Brother(s)	Sisters(s)	Other_____
Other:_____	Mother	Father	Brother(s)	Sisters(s)	Other_____

Social History

Do you or did you ever smoke or use chewing tobacco? Are you exposed to second hand smoke (circle yes if your parents smoke even if only outdoors)? YES / NO

a. If yes, please indicate:_____ packs per day for _____ years
b. Quite date: _____

Occupation (If child what grade?)

_____

Environmental History

Do you have or are you around pets? Please list all animals (indoor & outdoor) and number of each.

_____

Number of years lived in present home? _____

What type of flooring do you have? please circle

Carpeted Hardwood Tile Vinyl Other_____

What type of home heating do you have?

Oil/Gas Electric Coal Gas Fireplace Wood Fireplace Wood Stove Other_____

How often do you wash you sheets and comforters? _____

How old is your mattress? _____

Does your mattress and box spring have a dust mite cover?_____

Circle if you have these in your house.

Celling Fans Humidifier Air Filter Stuffed Animals Bookcases

Are you sensitive to perfumes? YES / NO

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Review of Systems

Please circle problems you have had within the last 6 months.

General:	Fever	Chills	Weight loss (unintended)	Weight gain
	Night sweats	Fatigue		
Eyes:	Itch	Pain	Excessive tears	Dryness
	Loss of Vision			
Ears/Nose/Throat:	Chronic nasal congestion	Chronic sinus infection	Frequent ear infection	Ringing in ear
	Ear tubes	Hearing loss	Dizzy spells	Snoring
	Sleep apnea	Frequent nose bleeds	Hoarseness	Frequent sore throats
	Trouble swallowing	Nasal polyps		
Lung and Chest:	Cough	Wheeze	Shortness of breath	Coughing up blood
	Coughing up phlegm			
Heart:	Chest pain	Palpitations	Irregular heartbeat	Swelling of ankles
Gastrointestinal:	Nausea	Vomiting	Abdominal pain	Diarrhea
	Constipation	Vomiting blood	Blood in stool heartburn	Bitter/acidic taste in mouth
Skin:	Hive	Rash	Itching	Swelling
Musculoskeletal:	Joint pain	Muscle pain or cramps	Joint swelling	
Genitourinary:	Pain or burning on urination	Frequent urination	Blood in urine	
Psych:	Anxiety	Depression		
Neuro:	Headaches	Seizures	Numbness or tingling	