Ocean State Asthma and Allergy **Patient's Medical History Questionnaire**

Please complete carefully and to the best of your knowledge – do not be concerned if you do not know the answer to all of the questions.

Patient's Name: _____ DOB: _____

Reason for Visit:_____

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I authorize Ocean State Asthma & Allergy to extract my external prescription history via the RX HUB service in their electronic medical records system. I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here and it may include prescriptions from several years past. My signature certifies that I have read and understood the scope of my consent and I authorize the access.

Patient (or Guardian) Signature:_____ Date:_____

Please list all current medications, herbals and vitamins:

Name/Strength/How Often	**Name/Strength/How Often**

Medication Allergies: **List:** **Reaction:**

Surgical History:

Procedure(s)	Date	Procedure(s)	Date

Hospitalization History:

Cause:	Date	Procedure(s)	Date

PAST MEDICAL HISTORY:

(Please circle if diagnosed or currently having these conditions)

CONSTITUTIONAL:
Fever / Chills
Cancer – Type _____

ALLERGY/IMMUNOLOGIC:
Allergies – Environmental
Angioedema (swelling of skin)
Hives
Recurrent infections – or rashes
Eczema
Food Allergy_____
Reactions to stinging insects
Autoimmune disease_____

CARDIOVASCULAR:
Chest pain or discomfort
Irregular or fast heart beat
History of heart murmur
History of Rheumatic Fever
History of heart failure
Congenital Heart Disease
Heart attack
High Blood Pressure
High Cholesterol

ENDOCRINE:
Diabetes-Type I or Type II
Underactive Thyroid
Overactive Thyroid
Low Blood sugar – Hypoglycemia

EYES:
Conjunctivitis (pink eye)
Allergic – Bacterial
Glaucoma

GASTROINTESTINAL:
Celiac Disease
GERD
Ulcers
Other food reactions_____

GENITOURINARY:
For Females -
Pregnant – YES or NO

HEMATOLOGIC:
HIV / AIDS
Anemia
Hepatitis

HENT:
Headaches – migraines
Otitis Media (ear infection)
Chronic Sinusitis

MUSCULOSKELETAL:
Fibromyalgia
Arthritis – Osteo or RA
Osteoporosis/Osteopenia

NEUROLOGICAL:
Seizures
Stroke – TIA

PSYCHIATRIC:
Depression
Anxiety
Bi-Polar Disorder

RESPIRATORY:
Bronchitis
Pneumonia
Asthma
Chronic cough
Shortness of breath
COPD – emphysema
Tuberculosis
Coughing up blood

OTHER MEDICAL CONDITIONS:
_____
_____
_____
_____

FAMILY HISTORY – Must be completed for immediate family (please circle all that apply)

A = Alive D=Deceased YOB=year of birth. (If unknown, please enter their age)

(Circle any of the illnesses they have below)

Father	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Mother	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Sibling 1	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Sibling 2	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Sibling 3	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Sibling 4	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Child 1	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Child 2	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Child 3	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown
Child 4	A or D	YOB/Age _____	Diabetes	Hypertension	Heart Disease	Stroke	Mental illness	Cancer	Unknown

Siblings	# of brothers	_____	# of sisters	_____	Healthy – YES NO
Children	# of sons	_____	# of daughters	_____	Healthy - YES NO

Asthma / Allergy Family History: Please list family member(s) and allergic conditions:

_____
_____
_____

SOCIAL HISTORY:

Smoking: Please circle if you are:

never smoker current smoker former smoker vaping use tobacco in other forms

Please circle form of tobacco: Cigarette Cigar Pipe Chewing tobacco Snuff

Current/Past smoking history – *please circle how many cigarettes you smoke – or did smoke per day*:

1-9 cigarettes 10-19 cigarettes 20-30 cigarettes 40+ cigarettes per day

If you stopped smoking – please answer questions below:

How many years did you smoke_____?

What age did you **start** smoking _____What age did you **stop** smoking_____

Are you currently: (Please circle one) **exposed** to second hand smoke **not exposed** to second hand smoke

Work Environment:

Occupation: _____

Environmental History: (Please circle all that apply)

Pillow Contents:	Cotton	Feather	Foam	Non-allergic	Polyester	Tempurpedic
Mattress Contents:	Air	Feather	Foam	Spring	Tempurpedic	Water
Comforter Contents:	Feather	Cotton	Polyester			
Dust Mite Covers:	Pillow	Mattress	None Used			
Flooring in Bedroom:	Carpet	Area rug	Wall to wall	Hardwood	Linoleum	Tile
Flooring in home:	Carpet	Area rug	Wall to wall	Hardwood	Linoleum	Tile
Pets:	None – Pet Free	Cat	Dog	Bird	Fish	Gerbil
	Guinea Pig	Hamster	Mouse	Rabbit	Other_____	
Pets at:	Mom's	Dad's	Grandparents	Babysitters	Daycare	Dorm

Farm Animals: Please list_____

Home Heated by: Forced hot air by gas Forced hot air by oil Forced hot air by propane
Forced hot water by gas Forced hot water by oil Forced hot water by propane
Electric baseboard Steam (radiator)
Coal Stove Pellet Stove Wood Stove

IMMUNIZATIONS:

Have you had a flu shot in the last year? YES_____ NO_____

If yes- please give date (or approximate date) of shot: _____

Have you had a pneumonia shot (Pneumovax) in the last year? YES_____ NO_____

If yes-please give date (or approximate date) of shot: _____

Have you been hospitalized in the last year? YES_____NO_____

If yes-please give date (or approximate date) of discharge: _____