## 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:_____
(Please Print)

Reason for Visit:_____

**Please list all current medications, herbals and vitamins:**

| Name/Strength | Dose | Frequency |
|---|---|---|
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |
| _____ | _____ | _____ |

**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:***
_____
_____
_____
_____

**Allergies / Intolerances / Sensitivities:** **Patient's Name:**_____

| **Allergies:** | **List:** | **Reaction:** |
|---|---|---|
| Food | _____ | _____ |
| Environmental | _____ | _____ |
| Drugs | _____ | _____ |
| Chemicals | _____ | _____ |

**Surgical History:**

| Procedure (s) | Date | Procedure (s) | Date |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |

**Hospitalization History:**

| Cause: | Date | Cause: | Date |
|---|---|---|---|
| _____ | | _____ | |
| _____ | | _____ | |

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

A = Alive D=Deceased YOB=year of birth. (If not known 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 condition-

_____
_____
_____

## SOCIAL HISTORY: Patient's Name:_____

**Smoking:** Please circle if you are:

never smoker current smoker former smoker 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:* _____