GLEN ALLERGY & ASTHMA NP ADULT FORM

NAME_____DOB_____DATE_____

REFERRED BY (IF PHYSICIAN PLEASE PROVIDE ADDRESS/PHONE):

_____

MEDICATIONS

(PRESCRIPTION/OTC/HERBAL/SUPLLEMENTS):

_____

_____

_____

_____

_____

DRUG/CONTACT ALLERGIES OR REACTIONS:

_____

_____

IV CONTRAST REACTION? Y N N/A

BEE/WASP STING REACTION? Y N

BANDAGES/MEDICAL TAPE Y N

CHEMICAL/POISON IVY Y N

MEDICAL HISTORY:

_____

_____

_____

_____

SURGERIES (TYPE AND DATES):

_____

_____

_____

_____

FAMILY HISTORY (CHECK BOX IF FAMILY MEMBER HAS BEEN DIAGNOSED WITH DISEASE):

	MOTHER	FATHER	SIBLING	GRANDPARENT	CHILD	OTHER
ALLERGIES (NASAL/EYE)						
ASTHMA						
ECZEMA						
FOOD ALLERGY						
DRUG ALLERGY						
HIVES						
IMMUNE PROBLEMS						
HEART DISEASE						
THYROID DISEASE						
DIABETES						
CANCER						
OTHER						

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NAME_____DOB_____

REASON FOR VISIT (DESCRIBE SYMPTOMS AND COMPLAINT):_____

_____

HOW LONG HAVE YOU HAD THIS PROBLEM?_____

HOW OFTEN DOES IT OCCUR? (TIMES PER DAY, WEEK, ETC)_____

HOW LONG DOES IT LAST?_____

ANY TIME OF YEAR IT IS WORSE? (OR CIRCLE THE MONTHS MOST SEVERE)_____

JANUARY FEBRUARY MARCH APRIL MAY JUNE JULY

AUGUST SEPTEMBER OCTOBER NOVEMBER DECEMBER ALL YEAR

WHAT MAKES IT WORSE? (ENVIRONMENT (DAMP/DRY, INDOORS/OUTDOORS,EXERCISE, ANIMALS,ETC):

_____

WHAT MAKES IT BETTER?_____

MEDICATIONS YOU HAVE TRIED? (ANTIHISTAMINES, NASAL STEROIDS, INHALERS, ANTIBIOTICS)_____

_____

PAST ALLERGIC/INFECTIOUS HISTORY (IF YES, PLEASE EXPLAIN)

NASAL ALLERGIES _____

EYE ALLERGIES_____

ASTHMA_____

ECZEMA (ATOPIC DERMATITIS)_____

HIVES_____

SWELLING (ANGIOEDEMA)_____

THROAT CLOSURE OR FULL BODY ALLERGIC REACTION (ANAPHYLAXIS)_____

_____

REACTIONS TO FOODS:

MILK:_____

EGGS:_____

WHEAT:_____

SOY:_____

PEANUTS:_____

TREENUTS/SEEDS:_____

SEAFOOD (FISH):_____

SHELLFISH:_____

INFECTIONS: (IF SO, HOW MANY TIMES PER YEAR)

SINUSITIS_____

EAR INFECTIONS (OTITIS MEDIA)_____

PNEUMONIAS_____

SKIN INFECTIONS_____

URINARY TRACT INFECTIONS_____

FREQUENT BOWEL INFECTIONS_____

OTHER_____

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PREVIOUS ALLERGY TESTING? Y N IF SO, RESULTS? _____ ALLERGY SHOTS? Y N

PRIOR PULMONARY FUNCTION TESTS? Y N IF SO, RESULTS?_____

PRIOR CT/SCANS/XRAYS OF SINUSES/CHEST Y N IF SO, RESULTS?_____

SOCIAL HISTORY

MARITAL STATUS: SINGLE MARRIED DIVORCED WIDOWED (CIRCLE ONE)

SMOKING HISTORY: _____YEARS _____PACKS/DAY QUIT? Y N IF SO, WHEN?_____

ALCOHOL : _____/WEEK ANY REACTIONS?_____

CAFFEINE: _____/DAY

OCCUPATION: _____ HOW LONG?_____

HOBBIES/SPORTS _____

ENVIRONMENTAL HISTORY:

HOME: SINGLE FAMILY HOME TOWNHOME APARTMENT CONDO OTHER

AGE OF HOME:_____ YEARS OF OCCUPANCY:_____

BASEMENT: Y N IF SO, ANY MOISTURE PROBLEMS?_____

AIR CONDITIONING: NONE CENTRAL ROOM UNIT SPACE PACK

HEATING: FORCED AIR RADIANT RADIATOR

PORTABLE HUMIDIFER Y N IF SO, HOW IS IT CLEANED _____

TOBACCO SMOKE EXPOSURE Y N IF SO, EXPLAIN FREQUENCY _____

SIGHT OR SMELL OF MOLD? Y N IF SO, EXPLAIN_____

PETS:_____ BREED:_____

HOW LONG?_____ ALLOWED INTO BEDROOM? Y N

REGULAR PET EXPOSURE OUTSIDE OF THE HOME? Y N

BEDROOM:

FLOORING IN BEDROOM:_____WINDOW TREATMENTS:_____

PILLOWS: SYNTHETIC DOWN/FEATHER COTTON FOAM

COMFORTERS: SYNTHETIC DOWN/FEATHER COTTON OTHER

USE OF DUST MITE ENCASEMENTS: Y N

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PLEASE CIRCLE THE SYMPTOMS THAT APPLY TO YOU:

HEAD AND NECK:

EYES: ITCHY RED SWOLLEN DRAINAGE

EARS: PAIN CLOGGED DECREASED HEARING

NOSE: CONGESTION SNEEZING ITCHING DRIPPING LOSS OF SMELL BLEEDING PAIN

THROAT: PAINFUL IRRITATED HOARSENESS CLEARING BURNING

RESPIRATORY:

SHORTNESS OF BREATH COUGH WHEEZING TIGHTNESS CHEST CONGESTION

CARDIOVASCULAR:

PALPITATIONS MURMUR SKIPPED OR IRREGULAR HEARTBEAT CHEST PAIN/ANGINA

ELEVATED BLOOD PRESSURE CLOTTING OF THE ARTERIES OR VEINS CHEST PAIN DURING EXERTION

GASTROINTESTINAL:

NAUSEA VOMITING DIARRHEA HEARTBURN FOOD IMPACTION (STUCK WITH SWALLOWING)

ABDOMINAL PAIN CRAMPING CONSTIPATION BLOOD IN STOOLS

SKIN:

RASH SWELLING HIVES ECZEMA PSORIASIS ITCHING BURNING CHANGE PIGMENT/ TEXTURE

MUSCULOSKELETAL:

JOINT ACHES MUSCLE SORENESS SWELLING WEAKNESS ARTHRITIS

NEUROLOGIC/PSYCH:

HEADACHES DIZZINESS VERTIGO TINGLING NUMBNESS DEPRESSION ANXIETY

GENITOURINARY:

BURNING ON URINATION BLOOD IN URINE KIDNEY STONES ENLARGED PROSTATE

GYNECOLOGIC (IF APPLICABLE):

ABNORMAL BLEEDING PELVIC PAIN

LAST MENSTRUAL CYCLE_____HOW MANY PREGNANCIES?_____CHILDREN_____

LAST MAMMOGRAM_____LAST PAP_____

ARE YOU PREGNANT OR PLANNING TO BECOME PREGNANT: YES NO

FORM COMPLETED BY_____DATE_____

OFFICE USE ONLY:

FORM REVIEWED BY:_____DATE_____