Patient history form

PATIENT#_____

Patient Name_____ Age:_____ Date of Birth ___/___/___ ( )Male ( )Female

Do you have Asthma? ( ) No ( ) Yes, Since what age?_____

Have you ever been hospitalized for difficulty breathing, wheezing or Asthma? ( )No ( ) Yes, how many times?_____

Have you ever been in an Intensive Care Unit (I.C.U.) for difficulty breathing? ( )No ( ) Yes, were you on a ventilator?_____

Have you ever been to an Emergency Room for difficulty breathing, wheezing or Asthma? ( )No ( ) Yes, how many times?_____

Have you ever been to a doctor's office Emergently for difficulty breathing, Wheezing or Asthma? ( )No ( ) Yes, how many times?_____

Do you have coughing or wheezing episodes at night 12:00 am-5:00 am? ( )No ( ) Yes, how many nights a week?_____

Do you cough or wheeze after physical Exertion? ( )No ( ) Yes, have you limited your activity?_____

Do you cough or wheeze upon exposure To cold air? ( )No ( ) Yes_____

Have you ever used an inhaled steroid? (e.g. Pulmicort, Flovent, Advair, Vanceril etc.) ( )No ( ) Yes, which one?_____

Have you ever used Albuterol, Xopenex Proventil or Combivent via inhalation? ( )No ( ) Yes, does it help your symptoms?_____

Have you ever had Wheezing? ( ) No ( )Yes, how many episodes?_____

Do you have chronic or persistent cough? ( )No ( ) Yes, for how long?_____

If you answered "Yes" to ANY of the questions above please answer the questions on page 2 in you answered "No" to ALL of the questions on this page you may skip page 2

1- Are there any triggers(e.g. pollen, cats, dog, upper respiratory infections, foods, insect sting, mold, smoke, perfumes, cosmetics, cleaners etc.) that exacerbate your respiratory condition?

_____

_____

2- Which of the following best describes the symptom frequency of your respiratory condition?

( ) Daily chronic symptoms.
( ) 2 or more times a week but not daily.
( ) Once a week on average.
( ) Symptoms only a couple of times a month.
( ) Symptoms only a monthly basis.
( ) Symptoms on a yearly basis.

3- What are/is the worst season for you? Check as many as necessary

( ) Winter ( ) Spring ( ) Summer ( ) Fall ( ) No Seasonal pattern

4- Is there a time of day during which your symptoms are worst? Check as many as necessary

( ) first few hours in the morning.
( ) During activity or exertion.
( ) Early Evening after dinner.
( ) Within the first 2 hours of going to bed.
( ) Very early in the morning
( ) Other _____

_____

5- What medications have you used or are currently using for your condition?

_____

_____

6- Do you get the flu shot every year? _____

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Patient Name_____ Age:_____ Date of Birth ___/___/___ PATIENT#_____

Do You have Any Drug Allergy?_____

_____

Do you have any food allergies? ( ) No ( ) Yes, What was your reaction like_____

_____

_____

Have you ever been Stung by a Hornet, Wasp or Bee ( ) No ( ) Yes, If so What was you reaction like?_____

_____

Have you ever had a reaction to Latex? ( ) No ( ) Yes, What was your reaction like_____

_____

Please List any and all medications and supplements you are taking

Medication	Dose

Medication	Dose

Please list ALL Medical conditions and/or any surgeries you 'v undergone below.

_____

_____

_____

_____