California Allergy & Asthma Medical Group, Inc.

Asthma, Allergy and Clinical Immunology

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PATIENT HISTORY

Today's Date: _____

Name of Patient: _____ Who Completed this form? _____

Address: (Street) _____ (City) _____ (State) _____

Home Ph. (_____) _____ Work Ph. (_____) _____ Occupation: _____

Briefly describe your problem(s) _____

ALLERGY HISTORY REVIEW

(check one)	Yes	No
Do your eyes itch?		
Do your eyes water?		
Are your eyes red?		
Are your ears clogged?		
Do your ears itch?		
Has your hearing decreased?		
Is your nose congested?		
Do you have nasal discharge?		
Do you sneeze?		
Does your nose itch?		
Do you get frequent colds?		
Does your mouth itch?		
Do you get sore throats?		
Do you have post nasal drip?		
Do you cough?		
Are you short of breath?		
Do you wheeze?		
Wheeze with exercise?		
Wheeze with laughter?		
Does your skin itch?		
Do you have hives?		
Is your skin red in places?		
Does your scalp itch?		

Which of the following cause symptoms: (check)	eyes	nose	ears	throat	skin	cough	wheeze
Spring							
Summer							
Fall							
Winter							
Change in weather							
Change in temperature							
Windy conditions							
Exercise							
House dust							
Work dust							
Moldy conditions							
Animal exposure							
Foods (list)							
1							
2							
3							
4							
5							
Smog							
Exhaust fumes							
Cleaning fluids							
Perfumes							
Cold temperatures							
Newsprint							
Tobacco smoke							

REVIEW OF SYSTEMS

Are you experiencing any of the following problems?

(check one)	Yes	No
Weight		
Appetite		
Weakness		
Fatigue		
Headaches		
Hearing		
Vision		
Swallowing		
Chest pains		
Shortness of breath		
Coughing up blood		
Stomach pain		
Vomiting		
Nausea		
Diarrhea		
Constipation		
Urination problems		
Muscle or Joint pain		
Skin problems		
Other		

FAMILY HISTORY

Have you or any family member experienced any of the following?

(check)	Patient	Mother	Father	Brothers	Sisters
Nasal problems					
Eczema					
Asthma					
Childhood bronchitis					
Hives					
Frequent colds					
Sinus infections					
High blood pressure					
Elevated cholesterol					
Cancer					
Emphysema					
Heart disease					
Kidney disease					
Other					

List the results of previous skin testing and x-rays if done:

PERSONAL HISTORY

Where were you born?	
How long lived in So. Cal?	
How long at current home?	
Hobbies? (list):	

HOME ENVIRONMENT

Pets now or in the past (please list)
Carpeting (locations)
Hardwood floors (locations)
Down (feather) pillow or comforters
Type of heater
Air conditioners

MEDICATION ALLERGIES

List medications that you are allergic to and/or intolerant of:

1
2
3
4
5
6
7
8
7
8
9
10

CURRENT MEDICATIONS

List medications that you are currently taking:

1
2
3
4
5
6
7
8
9
10