BLUEGRASS FAMILY ALLERGY

PERSONALIZED ASTHMA & ALLERGY CARE

KELLY S. BRAUER, MD, FACAAI

Patient Name: _____

Date of Birth: _____

INITIAL ALLERGY EVALUATION

Please describe in a few words the main medical problem which prompted you to seek evaluation today.

_____

SYMPTOMS: Are you bothered by the following symptoms?

Itchy/watery eyes	Facial pain/tenderness	Chest tightness
Dark circles under eyes	Nighttime cough	Itchy skin
Runny nose	Loss sense taste/smell	Dry skin
Stuffy nose/congestion	Chronic bad breath	Hives
Nasal itch/rub	History of nasal polyps	Swelling
Bouts of sneezing	Nosebleeds	Frequent ear infections
Ringing/popping ears	Cough	Frequent Pneumonia
Headaches	Wheeze	
Frequent sinus infections	Shortness of Breath	

AGGRAVATING FACTORS: Circle all the things that cause your symptoms.

Dust	Mold/mildew	Time of day – am/pm
Pollen	Colds/infections	Home
Cut grass/rake leaves	Indoors	Workplace
Cats	Outdoors	Temperature changes
Dogs	Weather changes	Food_____
Other animals_____	Smoke	
Feathers	Strong odors	

How long have you had symptoms? _____

Are symptoms worse in certain seasons? ☐Yes ☐No

Circle the worst season(s): ☐Spring ☐Summer ☐Fall ☐Winter

If you have been on antibiotics for sinus infections:

How many times have you been treated in the past 12 months? _____

What antibiotics have you used? _____

Have you ever received a CT scan, chest x-ray or sinus x-ray? ☐Yes ☐No

Have you ever had sinus surgery? ☐Yes ☐No

If you have had cough, shortness of breath, wheezing, or chest tightness:

Have you been on steroids or received a steroid shot for your breathing? ☐Yes ☐No

Have you ever been prescribed an inhaler? ☐Yes ☐No

Do you wake up at night because of chest symptoms? ☐Yes ☐No

Circle any circumstance appropriate to your asthma:

ER visits Hospitalization Intubation ICU admission Pneumonia

BLUEGRASS FAMILY ALLERGY

PERSONALIZED ASTHMA & ALLERGY CARE

KELLY S. BRAUER, MD, FACAAI

Patient Name: _____

Date of Birth: _____

If you have had hives or swelling:

How often do you have hives or swelling? _____ When did it first begin?_____

How long does each individual hive last? _____

Have you ever had hives/swelling in the past? ☐Yes ☐No

Do you experience shortness of breath, wheeze, chest tightness, abdominal pain, throat fullness, dizziness, or diarrhea? Yes No (circle where appropriate)

Have you recently experienced fevers, chills, night sweats, swollen glands, swollen joints, weight gain or loss? Yes No (circle where appropriate)

Current Medicines and Dosages (Prescription and Over-the-Counter):

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

Past Medical History/Review of systems

Have you ever been diagnosed with any of the conditions below? ☐Yes ☐No

	Yes	No		Yes	No
ADHD	☐	☐	Migraines/frequent headaches	☐	☐
Asthma	☐	☐	Nasal injury	☐	☐
Cancer	☐	☐	Osteoporosis or Osteopenia	☐	☐
Depression/anxiety	☐	☐	Positive TB skin tests/Tuberculosis	☐	☐
Developmental delay	☐	☐	Prematurity	☐	☐
Diabetes	☐	☐	Prostate disease	☐	☐
Elevated cholesterol	☐	☐	Recurring pneumonias	☐	☐
GERD/Ulcers/GI problems	☐	☐	Seizures/Neurologic disorder	☐	☐
Glaucoma/cataracts	☐	☐	Severe infections	☐	☐
Heart disease	☐	☐	Stroke	☐	☐
Hypertension	☐	☐	Thyroid disease	☐	☐
Irritable bowel syndrome (IBS)	☐	☐	Other _____		
Kidney stones	☐	☐			

_____

Surgical History

Please circle any surgeries you have previously had:

Adenoid removal	Gall bladder removal	Nasal/sinus surgery
Appendectomy	Hysterectomy	Open heart surgery
Ear tubes	Joint replacement	Tonsillectomy

Other: _____

Birth History

Were you born prematurely? ☐Yes ☐No If yes, how many weeks early? _____

Did you have any problems with breathing at birth? ☐Yes ☐No

BLUEGRASS FAMILY ALLERGY

PERSONALIZED ASTHMA & ALLERGY CARE

KELLY S. BRAUER, MD, FACAAI

Patient Name: _____

Date of Birth: _____

Any complications/hospital stays in the first year? ☐Yes ☐No
Any developmental delays or special evaluations required? ☐Yes ☐No

Immunization History
Are your routine childhood vaccinations up to date? ☐Yes ☐No if no, why? _____
Do you get a flu shot? ☐Yes ☐No
Have you ever had a reaction to shots? ☐Yes ☐No Please describe _____

Allergy History
Any medication allergies? ☐Yes ☐No Please list and describe reaction:
_____
_____
_____

Any problems related to diet? ☐Yes ☐No Please describe:
_____
_____
_____

Any insect sting reactions? ☐Yes ☐No _____
Any latex reactions? ☐Yes ☐No _____
Prior allergy testing? ☐Yes ☐No
Were you on injections? ☐Yes ☐No if yes, did they help? ☐Yes ☐No

Family History
Do any of your <u>family members</u> have a history of:

	Who: (father, mother, grandmother, etc.)
☐ Asthma	_____
☐ Cystic Fibrosis	_____
☐ Eczema	_____
☐ Food allergies	_____
☐ HayFever	_____
☐ Hives/Swelling	_____
☐ Insect Sting Reactions	_____
☐ Migraines/headaches	_____
☐ Recurrent infections	_____
☐ Stomach problems	_____
☐ Other	_____
	_____

SOCIAL HISTORY
(please circle)

1.	Marital status:	Married	Divorced	Single	Widowed
2.	Alcohol use:	Never/rarely	Socially	More than 3x/week	
3.	Exercise:	Never/rarely	Occasionally	More than 3x/week	

BLUEGRASS FAMILY ALLERGY
PERSONALIZED ASTHMA & ALLERGY CARE

KELLY S. BRAUER, MD, FACAAI

Patient Name: _____
Date of Birth: _____

4. Drug Use: Never In the Past Currently
5. Tobacco Use: Never In the Past Currently

If you answered yes to Tobacco use, please answer the following:
How much? _____
For how many years? _____
If you have quit, when did you stop? _____

Work/School/Daycare

1. What is your occupation? _____
2. If a student, what grade are you in? _____
3. What are your hobbies? _____
4. Are your symptoms worse at work? ☐Yes ☐No
5. Any specific exposures at work? ☐Yes ☐No _____
6. Do you get better on vacation? ☐Yes ☐No
7. How many days did you miss school or work in the past year? _____
8. If child, is he/she in daycare? ☐Yes ☐No
9. How many other persons are in the household? _____

ENVIRONMENTAL HISTORY
General (circle where appropriate)

1. Where do you live? House Apartment Trailer Condo Other: _____
2. How long have you lived there? _____ How old is it? _____
3. Pets (If yes please specify) ☐Yes ☐No

☐Cat	☐Indoor	☐Outdoor	☐Both
☐Dog	☐Indoor	☐Outdoor	☐Both
☐Other:_____	☐Indoor	☐Outdoor	☐Both

4. Smokers in the home? ☐Yes ☐No
5. Is your home air conditioned? ☐Yes ☐No If yes, central or window?
6. Do you keep your windows closed? ☐Yes ☐No
7. Do you have a humidifier? ☐Yes ☐No
8. Do you have an electrostatic air filter? ☐Yes ☐No
9. Do you have moisture problems in your home? ☐Yes ☐No
10. Do you have a basement? ☐Yes ☐No Is it damp? ☐Yes ☐No
11. Do you have: ☐ Carpet ☐Wood ☐Vinyl flooring
12. Have you noticed insects or cockroaches in the home? ☐Yes ☐No

ADDITIONAL HISTORY:
Is there any information you think we should know not mentioned elsewhere on this form?

_____
_____
_____
_____