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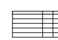
Patient History

Please answer every question.

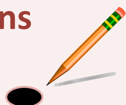


STAFF: Handwritten responses must be entered **MANUALLY**.

PLEASE PRINT PATIENT'S LAST NAME

Marking Instructions

Please use a #2 pencil.
Fill in the complete oval as shown...



PLEASE PRINT PATIENT'S FIRST NAME

PATIENT'S DATE OF BIRTH

Month Day Year

TOBACCO USE

What is the patient's smoking status? never ◯ previous ◯ current (some days) ◯ current (every day) ◯

At what age did the patient begin smoking? n/a ◯ <10 ◯ 10-20 ◯ 21-30 ◯ 31-40 ◯ >40 ◯

If the patient quit smoking, at what age did the patient quit? n/a ◯ <10 ◯ 10-20 ◯ 21-30 ◯ 31-40 ◯ >40 ◯

How many packs per day does the patient smoke now (or in the past)? n/a ◯ < ½ ◯ ½-1 ◯ 1-2 ◯ >2 ◯

Is the patient exposed to passive (second hand) smoke? yes ◯ no ◯

If yes, how often? daily ◯ few times per week ◯ rarely ◯

ALCOHOL USE

How often does the patient use alcohol?

number of times... never ◯ 1 ◯ 2 ◯ 3 ◯ 4 ◯ 5 ◯ 6 ◯ 7+ ◯

per... week ◯ month ◯ year ◯

(If you marked "**never**", please skip ahead to **DRUG USE** section)

What type(s) of alcohol does the patient drink? beer ◯ wine ◯ liquor ◯

How many drinks does the patient have per occasion? 1-2 ◯ 3-5 ◯ 6-9 ◯ 10+ ◯

DRUG USE

none ◯ current ◯ previous ◯ prefer to discuss with physician ◯

TRAVEL

Did the patient travel outside of North America within the last year? yes ◯ no ◯

If yes, where? ____

HABITS

How often does the patient wear a seatbelt / car seat? always ◯ almost always ◯ occasionally ◯ never ◯

PET HISTORY

Does the patient have any of the following pets?
If yes, please answer whether they stay inside, outside and/or lay on the patient's bed.

Pet					
Dog	no ◯	yes ◯	inside ◯	outside ◯	pet in bed ◯
Cat	no ◯	yes ◯	inside ◯	outside ◯	pet in bed ◯
Bird	no ◯	yes ◯	inside ◯	outside ◯	
Horse	no ◯	yes ◯			
Other	no ◯	yes ◯	inside ◯	outside ◯	

(please specify animal): ____________________________

(U.S. Patent No. 7,487,102) (U.S. Patent No. 7,941,328)

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SAMPLE

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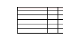
Patient History

Please answer every question.



STAFF: Handwritten responses must be entered **MANUALLY**.

SOCIAL ENVIRONMENT

Please indicate if THE PATIENT has the following items in the home:

Bedroom carpet	yes ◯	no ◯
Family room carpet	yes ◯	no ◯
Mold problem inside the home	yes ◯	no ◯
Central air	yes ◯	no ◯
Central heat	yes ◯	no ◯
Disposable filters	yes ◯	no ◯
If yes, how frequently are they changed?	monthly ◯ 1-2 months ◯	3-5 months ◯ >5 months ◯
Dust mite encasings for pillow(s)	yes ◯	no ◯
Dust mite encasings for mattress	yes ◯	no ◯
Bedding	synthetic ◯	feather ◯
Pillow	synthetic ◯	feather ◯

Is the patient's living environment: apartment ◯ single family home ◯ mobile home ◯ dorm room ◯ other (please specify): ◯ ____________

PAST MEDICAL HISTORY

Has the patient ever been hospitalized for asthma?	yes ◯	no ◯
Has the patient ever had a skin test?	yes ◯	no ◯
Has the patient ever had a RAST (blood) allergy test?	yes ◯	no ◯
Has the patient ever had allergy shots?	yes ◯	no ◯
Are the patient's immunizations up to date?	yes ◯	no ◯
Does the patient have a medication allergy?	yes ◯	no ◯

YOUR MEDICAL HISTORY

Please indicate if THE PATIENT has a history of the following. Mark all that apply.

- ◯ Anaphylaxis
- ◯ Asthma
- ◯ Nasal Allergies
- ◯ Sinus Infections, Recurrent
- ◯ Pneumonia, Recurrent
- ◯ Hives
- ◯ Swelling (Angioedema)
- ◯ Eczema
- ◯ Emphysema (COPD)
- ◯ Contact Dermatitis
- ◯ Sting Reaction (please specify insect): ____________
  - Sting Reaction Location: ◯ local ◯ systemic
- ◯ Food Allergy (please specify): ____________
- ◯ Latex Allergy
- ◯ Eye Allergies
- ◯ Immune Deficiency
- ◯ Arrythmia
- ◯ Anemia
- ◯ Anxiety Disorder
- ◯ Arthritis
- ◯ Autoimmune Problems
- ◯ Birth Defects
- ◯ Blood Transfusion(s)
- ◯ Breast Cancer
- ◯ Cervical Cancer
- ◯ Colon Cancer
- ◯ Depression
- ◯ Diabetes
- ◯ Ear Infections
- ◯ Growth / Development Disorder
- ◯ Heart Disease
- ◯ High Blood Pressure
- ◯ High Cholesterol
- ◯ HIV
- ◯ Kidney Disease
- ◯ Liver Cancer
- ◯ Liver Disease
- ◯ Lung Cancer
- ◯ Mental Illness
- ◯ Migraines
- ◯ Osteoporosis (Osteopenia)
- ◯ Prostate Cancer
- ◯ Rectal Cancer
- ◯ Reflux / GERD
- ◯ Seizures / Convulsions
- ◯ Skin Cancer
- ◯ Thyroid Problems
- ◯ **NONE OF THE ABOVE**

PATIENTS UNDER 18 ONLY

Was the patient breastfed?			yes ◯	no ◯
If yes, how long?	<1 month ◯	1-3 months ◯	3-6 months ◯	>6 months ◯
Was the patient born prematurely?			yes ◯	no ◯
If yes, how early?	<28 weeks ◯	28-30 weeks ◯	30-33 weeks ◯	>33 weeks ◯
Did the patient have respiratory problems at birth?			yes ◯	no ◯
Did the patient have a formula or other food intolerance / reaction?			yes ◯	no ◯

If yes, to which food(s)?____________

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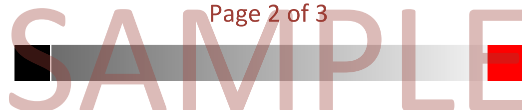
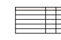


Patient History

Please answer every question.



STAFF: Handwritten responses must be entered **MANUALLY**.

FAMILY MEDICAL HISTORY

- ◯ FAMILY HISTORY UNKNOWN
- ◯ ADOPTED
- ◯ NO SIGNIFICANT FAMILY MEDICAL HISTORY

Please indicate which of THE PATIENT'S FAMILY MEMBER(S) have had these illnesses:

	Mother	Father	Sibling (brother or sister)
Arthritis	◯	◯	◯
Asthma	◯	◯	◯
Breast Cancer	◯	◯	◯
Colon Cancer	◯	◯	◯
COPD	◯	◯	◯
Depression	◯	◯	◯
Diabetes	◯	◯	◯
Eczema	◯	◯	◯
Heart Disease	◯	◯	◯
High Blood Pressure	◯	◯	◯
High Cholesterol	◯	◯	◯
Immune Disorder	◯	◯	◯
Kidney Disease	◯	◯	◯
Migraines	◯	◯	◯
Nasal Allergies	◯	◯	◯
Osteoporosis	◯	◯	◯
Recurrent Pneumonia	◯	◯	◯
Recurrent Sinusitis	◯	◯	◯
Swelling (Angioedema)	◯	◯	◯
Thyroid Problems	◯	◯	◯
Other Cancer	◯	◯	◯

SURGICAL HISTORY

Please indicate if THE PATIENT has had any of the following surgeries:

- ◯ PATIENT HAS HAD NO SURGERIES
- ◯ Adenoidectomy
- ◯ Sinus Surgery
- ◯ Tonsillectomy
- ◯ Deviated Nasal Septum
- ◯ Appendectomy

Ear Tubes	◯ left	◯ right	◯ both	◯ multiple times
Gallbladder Surgery	◯ open	◯ laparoscopic		
Hysterectomy	◯ partial	◯ complete		
Lung Surgery	◯ left	◯ right		
Kidney Removal	◯ left	◯ right		
Cataract Surgery	◯ left	◯ right	◯ both	
Breast Cancer Lump Removal	◯ left	◯ right	◯ both	
Mastectomy	◯ left	◯ right	◯ both	
Ovary Removal	◯ left	◯ right	◯ both	
Thyroid Removal	◯ left	◯ right	◯ total	◯ partial
Heart Valve Replacement	◯ mitral	◯ aortic	◯ tricuspid	◯ unknown valve
Heart Bypass Surgery	◯ 1 vessel ◯ 2 vessels	◯ 3 vessels ◯ 4 or more vessels	◯ unknown number of vessels	

◯ **OTHER SURGERY** (please specify): ____________________

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SAMPLE