Allergy & Asthma Medical Group of the Bay Area, Inc
New Patients

Name:_____ DOB:_____ Visit Date:_____

Referred to our office by:_____
Pharmacy: _____
Mail Order Pharmacy: _____

Main Reason for Visit:_____

When did Symptom start? Onset:_____days/mos/yrs Duration:____days/mos/yrs

Severity: □ mild □ moderate □ severe □ incapacitating

Frequency: □ intermittent □ persistent □ occasional

Status (Currently): □ resolved □ improved □ no change □ worsened

Aggravated by: ☐ Nothing

- ☐ airborne chemicals
- ☐ animals
- ☐ cat
- ☐ change in weather
- ☐ cold air
- ☐ dog
- ☐ dust/dust mites
- ☐ exercise
- ☐ foods
- ☐ molds
- ☐ nasal decongestant spray
- ☐ pollen
- ☐ respiratory infections
- ☐ smoke
- ☐ stress
- ☐ strong odors / perfume
- ☐ winter
- ☐ spring
- ☐ summer
- ☐ fall

Timing:

- ☐ morning
- ☐ evening
- ☐ bedtime
- ☐ lying down
- ☐ on wakening
- ☐ night worsening
- ☐ at home
- ☐ at work/school
- ☐ inside
- ☐ outside
- ☐ with URI's
- ☐ with weather changes
- ☐ seasonally
- ☐ winter
- ☐ spring
- ☐ summer
- ☐ fall
- ☐ year round
- ☐ other:_____

Other Medical History

- ☐ Allergies (nose/eyes)
- ☐ Anemia/low red cells
- ☐ Angina (heart-related chest pain)
- ☐ Anxiety/depression
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial fibrillation
- ☐ Autoimmune disease_____
- ☐ Benign prostate enlargement
- ☐ Blood clots
- ☐ Cancer _____
- ☐ Stroke
- ☐ COPD/emphysema
- ☐ Heart disease
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ Gallbladder disease
- ☐ Heartburn
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ High cholesterol
- ☐ High blood pressure
- ☐ Irritable bowel
- ☐ Liver disease
- ☐ Migraine headaches
- ☐ Heart attack
- ☐ Osteoporosis
- ☐ Peptic ulcer disease/stomach ulcers
- ☐ Pneumonia
- ☐ Kidney disease_____
- ☐ Multiple Sclerosis
- ☐ Seizure disorder
- ☐ Thyroid disease_____
- ☐ Tuberculosis
- ☐ Other_____

Past Surgical History

- ☐ Adenoidectomy
- ☐ Angioplasty
- ☐ Angioplasty +stent
- ☐ Appendectomy
- ☐ Back surgery
- ☐ Coronary bypass
- ☐ Carpal tunnel
- ☐ Cataract
- ☐ Gall bladder
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Colostomy
- ☐ Hernia repair
- ☐ Knee replacement
- ☐ LASIK
- ☐ Liver biopsy
- ☐ Ear tubes
- ☐ Fracture repair
- ☐ Pacemaker
- ☐ Sinus surgery
- ☐ Small bowel resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Breast augmentation
- ☐ Tubal ligation
- ☐ Breast biopsy
- ☐ C-section
- ☐ D and C (Uterus)
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Fibroid removal
- ☐ Breast reduction
- ☐ Hysterectomy and ovary removal
- ☐ Vaginal hysterectomy
- ☐ Prostate biop.
- ☐ Prostate
- ☐ Vasectomy
- ☐ other_____

Family History

❒ Check if Adopted

	MOTHER	FATHER	SISTER	BROTHER	CHILDREN	OTHER RELATIVE
Allergies—nasal or eye						
Asthma						
COPD, emphysema or cystic fibrosis						
Eczema						
Food allergies						
Recurrent sinus or lung infection						
Smoker						
Other significant illnesses						

Social History

Tobacco use ☐ Current ☐ Former ☐ Never ☐ Unknown type _____ packs per day_____
Years smoked _____ Ever tried to quit ☐yes ☐no yr quit_____ Longest Tobacco Free _____
Relapse Reason_____ Passive smoke exposure ☐ yes ☐ no
☐ Current every day smoker ☐ Smoker, current status unknown ☐ Former smoker
☐ Current some day smoker ☐ Never smoker ☐ Unknown, if ever smoked
Alcohol use ☐ yes ☐ no ☐former type _____ frequency_____ amount _____ last drink_____
Caffeine user ☐ yes ☐ no type(s)_____ _____ amount daily _____
Drug Use ☐ yes ☐ no ☐former type(s)_____

Current Allergy/Asthma Medications

(drug name)	(strength)	(number of times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Current Medications for Other Conditions

(drug name)	(strength)	(number of times per day)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Homeopathic/Herbal/Complimentary/Alternative treatments:_____

Drug Allergies_____

Other Symptom Review (circle those that you are experiencing):

General:
Chills
Fatigue
Fever
Weakness
Night Sweats
Weight gain
Weight loss

Respiratory:
Rapid breathing
Chronic Cough
Cough
Frequent URI
Coughing up blood
Known TB exposure
Sharp, painful breathing
Shortness of breath
Coughing up sputum
Tight throat
Extra muscles to breathe
Wheezing
Other: _____

Stomach/Intestines:
Abdominal pain
Bloating
Blood in stools
Change in stools
Constipation
Diarrhea
Heartburn
Loss of appetite
Nausea
Reflux
Vomiting
Other: _____

Neurological:
Inappropriate interaction
Dizziness
Extremity numbness
Extremity weakness
Walking Disturbances
Headache
Incoordination
Lightheadedness
Memory loss
Seizures
Tremors
Sense of room spinning
Other: _____

Musculoskeletal:
Back Pain
Bone/joint symptoms
Joint pain
Joint swelling
Muscle weakness
Neck pain
Other: _____

Head/Eyes/Ears/Throat:
Trouble swallowing
Ear drainage
Ear infection
Ear pain
Eye discharge
Eye pain
Eye redness
Hearing loss
Hoarseness
Itchy eyes
Nasal congestion
Nasal drainage
Post nasal drip
Runny nose
Sinus pressure
Sneezing
Sore throat
Tearing
Visual changes
Other:: _____

Cardiovascular:
Chest pain
Pain in legs with walking
Areas of body turn blue/purple
Swelling
Trouble breathing at night
Shortness of breath when lying down
Irregular heartbeat
Fainting
Other: _____

Hematologic/Lymphatic:
Easy bleeding
Easy bruising
Swollen glands
Other: _____

Metabolic/Endocrine:
Abnormal sleep pattern
Cold intolerance
Goiter
Heat intolerance
Increased activity
Excessive thirst
Excessive hunger
Other: _____

Psychiatric:
Anxiety
Depression
Insomnia
Other: _____

Skin:
Brittle hair
Brittle nails
Frequent skin infections
Hair loss
Excessive hair growth
Hives
Itchiness
Mole changes
Rash present
Skin lesion
Other: _____

Immunologic:
Bee sting allergies
Contact allergy
Environmental allergies
Food allergies
Seasonal allergies
Other:_____

Home/Work Environment

Area of residence during early life ❒Bay Area ❒Other_____
Hobbies_____
Symptoms increased at work ❒yes ❒no Explain if yes_____

Current Residence 1

Type_____ Age of building_____
How long have you lived at your current residence?_____
❒Yard ❒Ranch ❒Farm ❒Near open fields
Smokers in home ❒yes ❒no
❒Self ❒Spouse ❒Father ❒Mother ❒other_____
Type of Bed: ❒Boxspring ❒Waterbed ❒Foam ❒Crib ❒Allergy Covered
Down Bedding? ❒Pillow ❒Comforter ❒Featherbed ❒Blanket
Bedroom: ❒Carpeted ❒Blinds ❒House Plants
❒Books ❒Drapes ❒Stuffed animals
Type of Floors: ❒Carpet ❒Hardwood ❒Tile ❒Large Area Rug
Vacuum ❒Regular ❒HEPA ❒Central
Any damp, moldy areas of house? ❒Yes ❒no _____
Infestation with: ❒mice ❒rats ❒cockroaches ❒other_____
Animals in the home ❒yes ❒no
Type(s) _____ Numbers:_____
Kept Inside ❒yes ❒no
Kept in Bedroom ❒yes ❒no

Current Residence 2

Type_____ Age of building_____
How long have you lived at your current residence?_____
❒Yard ❒Ranch ❒Farm ❒Near open fields
Smokers in home ❒yes ❒no
❒Self ❒Spouse ❒Father ❒Mother ❒other_____
Type of Bed: ❒Boxspring ❒Waterbed ❒Foam ❒Crib ❒Allergy Covered
Down Bedding? ❒Pillow ❒Comforter ❒Featherbed ❒Blanket
Bedroom: ❒Carpeted ❒Blinds ❒House Plants
❒Books ❒Drapes ❒Stuffed animals
Type of Floors: ❒Carpet ❒Hardwood ❒Tile ❒Large Area Rug
Vacuum ❒Regular ❒HEPA ❒Central
Any damp, moldy areas of house? ❒Yes ❒no _____
Infestation with: ❒mice ❒rats ❒cockroaches ❒other_____
Animals in the home ❒yes ❒no
Type(s) _____ Numbers:_____
Kept Inside ❒yes ❒no
Kept in Bedroom ❒yes ❒no

Occupation: _____

If you have a diagnosis of Asthma, Please complete the following questionnaire:

If you have asthma, ages 12-Adult, please fill out the Asthma Control Test information below:

1. In the past **4 weeks**, how much of the time did your **asthma** keep you from getting as much done at work, school or at home?
   ❒ All of the time ❒Most of the time ❒Some of the time ❒A little of the time ❒None of the time
2. During the past **4 weeks**, how often have you had shortness of breath?
   ❒More than once day ❒Once a day ❒3 to 6 times a week ❒Once or twice a week ❒Not at all
3. During the past **4 weeks**, how often did your **asthma** symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?
   ❒4 or more nights a week ❒2or 3 nights a week ❒Once a week ❒Once or twice ❒Not at all
4. During the past **4 weeks**, how often have you used your rescue inhaler or nebulizer medication (such as albuterol)?
   ❒3 or more times per day ❒1 or 2 times per day ❒2 or 3 times per week ❒Once a week or less ❒Not at all
5. How would you rate your **asthma** control during the past **4 weeks**?
   ❒Not controlled at all ❒Poorly controlled ❒Somewhat controlled ❒Well controlled ❒Completely controlled

If you have asthma, ages 4-11, please fill out the Asthma Control Test information below:

1. How is your Asthma today?
   ❒Very Bad ❒Bad ❒Good ❒Very Good
2. How much of a problem is your asthma when you run, exercise or play sports?
   ❒It's a Big Problem, Can't do what I want ❒It's a Problem, I don't like it ❒It's a Little Problem but it's ok ❒It's not a Problem
3. Do you cough because of your asthma?
   ❒Yes, All of the time ❒Yes, Most of the time ❒yes, Some of the time ❒No, None of the time
4. Do you wake up during the night because of your asthma?
   ❒Yes, All of the time ❒Yes, Most of the time ❒yes, Some of the time ❒No, None of the time
5. During the last 4 weeks, how many days did your child have daytime asthma symptoms?
   ❒Not at all ❒1-3 days ❒4-10 days ❒11-18 days ❒19-24 days ❒Everyday
6. During the last 4 weeks, how many days did your child wheeze during the day because of asthma?
   ❒Not at all ❒1-3 days ❒4-10 days ❒11-18 days ❒19-24 days ❒Everyday
7. During the last 4 weeks, how many days did your child wake up during the night because of asthma?
   ❒Not at all ❒1-3 days ❒4-10 days ❒11-18 days ❒19-24 days ❒Everyday

For Office Use Only:

Form reviewed with: ❒patient ❒father ❒mother ❒other_____ _____, M.D.