Allergy/Asthma Specialists W. MI
Vincent Dubravec, MD, FACAAI

PLEASE COMPLETE BEFORE YOUR APPOINTMENT

NAME:_________________________________ **Date:**_________**Primary care provider:**______________

[1] Circle 3 to 5 most bothersome NASAL / EYE SYMPTOMS: (IF NONE, SKIP)

Runny nose | Stuffy nose | Sneezing | Discolored nasal discharge | throat clearing
Post nasal drip | Itchy nose | Rubbing nose | Loss of smell | Loss of taste
Mouth breathing | Snoring | Sniffling | Red eyes | Cough
Itchy eyes | Watery eyes | Dry eyes | Puffy eyes | Rubbing eyes
Headaches

Other:____

***How long have you had these symptoms?**_________________________________

Medications tried for nose and eye symptom: (pills, nasal sprays, eye drops, other)

Name of drugs	How long tried?	helped	Some help	No help

[2] Ever diagnosed with ASTHMA? (circle) NO / YES- when diagnosed:________________

- IF NO, Ever been given asthma medications, inhalers, breathing treatments? NO / YES
  - ✓ *If YES*, which ones:____

Circle up to 5 most bothersome CHEST SYMPTOMS: (IF NONE, SKIP to [3])

Trouble breathing | Chest tightness | Frequent cough | Cough at night | Wheezing
Cough | Cough or wheeze with exercise/play | Cough after eating | Rattly chest

Other:(*PostTussiveEmesis*)____

ACT: ______

-Does exercise/activity trigger cough or wheeze? (circle) NO / Sometimes / Often

-***Typically***, any **nighttime or** early **morning cough** NONE/ ____(enter#) times a week.
 -WHEN? First lie down / middle of night / morning awakening

- Any HOSPITALIZATIONS for **asthma** or other **breathing** problems? NO / YES
  - ✓ *IF YES:* How many times?________ When was that last time?_____________
    Ever in ICU (intensive care unit)? NO / YES when?_____________
- Any ER/URGENT CARE visits for **asthma** or other **breathing** problems? NO / YES
  - ✓ *IF YES:* How many times?________ When was that last time?_____________
- Any PREDNISONE / ORAL STEROID PILLS or syrups for **breathing** flare? NO / YES
  - ✓ *IF YES:* How many times?________ When was that last time?_____________
- **Quick relief inhaler used** (like Albuterol, Proventil, Ventolin, Maxair) _____ times a month / week / day
- Does the Quick Relief inhaler help? NO / YES
- **Spacer?** ☐ No ☐ Yes ☐ with mouthpiece ☐ with facemask
- **Peak Flow Meter?** ☐ No ☐ Yes, typically runs __________ .

[3] Symptoms are: Year-round OR/AND Worse during (circle months)

NOSE/EYES: Year Round / Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

Chest/Asthma: Year Round / Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4 ALLERGY SURVEY

a. Previous Allergic Investigation –

By whom: ______________________________ When______________________________
Results of test: ______________________________
Allergy Shots? ☐ No ☐ Yes →Any significant reactions? ☐ No ☐ Yes → ______________________
For how long? ______________________________ Did shots help? ______________
Reason Treatment stopped: ______________________________

b. Occupational History—

Employer______________________________
Specific Job______________________________
Difference in symptoms at work/home______________________
Change in symptoms on vacation ______________________

IF CHILD:
In Daycare/Preschool?______
Since when? ____________
____days per week

c. Living Accommodations –

☐ House ☐ Apartment ☐ Mobile Home • ☐ City ☐ Town ☐ Country
Age of home ______ Years lived in this location _____
Prior occupants with pets? ☐ No ☐ Yes: _____
Basement: ☐ Yes ☐ No • ☐ Finished ☐ Carpet ☐ Damp ☐ Dry ☐ Dirt
Heating: ☐Forced Air ☐Space Heat ☐Hot Water ☐Wood Burn ☐Gas ☐Electric
Air Conditioning: ☐Yes ☐No • ☐Central ☐Unit ☐Room
Humidifier: ☐Yes ☐No • ☐Central ☐Unit • Dehumidifier: ☐Yes ☐ No

Bedroom—

Sleeps on: ☐Mattress ☐Waterbed
Pillow: ☐Foam ☐Feather ☐Polyester
Stuffed Animals in bedroom: ☐Yes ☐No
Floor: ☐Carpet ☐Wood ☐Linoleum

Living Room—

Floor: ☐Carpet ☐Wood ☐Linoleum

(Continued)—
Water leak problems ☐No ☐Yes:
Obvious mold problems ☐No ☐Yes:

d. Pets? – ☐YES ☐NO

☐Outdoors ☐Indoors What kind?______________________________
How long have you had the pets? ______________________________
☐ Exposure to friends'/relatives' pets? What kind?______________________________
Symptoms around pets: ______________________________

e. Smoking Exposure? – ☐YES ☐NO

☐Patient ☐Father ☐Mother ☐Spouse ☐Others
Prior smoking? ☐No ☐Yes: how long ___yrs; packs per day ___ When stopped: ________

f. Allergy to Food? – ☐YES ☐NO

Food ______________________________ Reaction: ______________________
Food ______________________________ Reaction: ______________________

g. Allergy to Medications? – ☐YES ☐NO

Medication ______________________________ Reaction: ______________________
Medication ______________________________ Reaction: ______________________

h. Severe Insect Stings Reactions?— ☐YES ☐NO ☐ NEVER BEEN STUNG

☐ Large Swelling ☐Hives on other parts of the body ☐Breathing problems ☐Dizziness or fainting
☐Other:______________________________

i. Ever been prescribed and Epi injector? – ☐YES ☐NO

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5 Check triggers:

	Nose/Eyes	Chest		Nose/Eyes	Chest		Nose/Eyes	Chest
Dust			Tobacco smoke			Food		
Mowed grass			Colds/Viruses			Exercise		
Pets: (what kinds)			Strong Odors			Cold air		
			Wind			Humid days		
Weather changes			Stress			Air conditioning		
Others:			Raking leaves			perfumes		

Family history (please check all that apply):

	Father	Mother	Brother(s)	Sister(s)	Children
Migraine					
Hives					
Emphysema					
Asthma					
Eczema					
Hayfever/Nasal Allergies					
Thyroid Disease					

6 LIST ALL CURRENT MEDICATIONS & SUPPLEMENTS and how often you take them.

____
____
____

7 REVIEW OF SYSTEMS: (Please circle all that pertain):

Heart: NONE / Heart murmurs / palpitations / irregular heartbeat / other heart problem:
GI: NONE / Heart burn, acid reflux / Trouble Swallowing / Diarrhea / constipation / abdominal pain / cramps / bloating
GU: NONE / Bedwetting / incontinence / frequency / urgency / enlarged prostate
Skin: NONE / Diaper rash cradle cap thrush eczema hives
Hives: NONE / Triggers- stress cold exercise hot shower vibration pressure points sun

8 PAST MEDICAL HISTORY: (Please circle all that pertain)

Facial Trauma / Sinus CT scan / Nasal polyps / Migraines / Frequent Sinusitis / Thyroid Problems / High Blood Pressure/ Compromised immune system / Arthritis / Joint Problems / Osteoporosis / Tuberculosis

***[If A Child]*:** Pregnancy/delivery: Full-term / Premature Growth and Development: Normal / Vomiting / Spitting

Immunizations: Up-to-date / Flu shot / Pneumovax/ missing:___________________________________]

Surgeries: tonsils / adenoids / sinuses / ear tubes / other:____

Hospitalizations: _________________________________ ER Visits:_________________________

Any Other Important Medical History?:____

******Please bring in ANY INHALERS, PEAK FLOW METERS, AND SPACERS.******