

ALLERGY & ASTHMA CARE

OF SAINT LOUIS

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HEALTH HISTORY QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name (Last, First, MI): _____ Age: _____ Date: _____

Preferred Name: _____ Date of Birth: _____

Referring Physician: _____ Primary Care Physician (PCP): _____

I give my permission to send a written report(s) to the above Doctor(s): ☐ Yes ☐ No

Family members who are also patients: _____

BRIEFLY DESCRIBE THE REASON(S) FOR THIS VISIT:

ALLERGY / IMMUNOLOGY HISTORY			
YES		NO	Have you ever had the following conditions:
CURRENT problem	PAST problem		Elaborate:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic Rhinitis (hay fever/seasonal allergies) <input type="checkbox"/> Spring <input type="checkbox"/> Summer <input type="checkbox"/> Fall <input type="checkbox"/> Winter <input type="checkbox"/> Year-round <input type="checkbox"/> Runny <input type="checkbox"/> Stuffy <input type="checkbox"/> Sneezing <input type="checkbox"/> Itching <input type="checkbox"/> Loss of Smell Triggers:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nasal Polyps <input type="checkbox"/> Prior surgery? Date(s):
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Allergic conjunctivitis (itchy/watery eyes) <input type="checkbox"/> Seasonal <input type="checkbox"/> Year-round <input type="checkbox"/> Itchy <input type="checkbox"/> Watery <input type="checkbox"/> Swollen
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Asthma <input type="checkbox"/> Cough <input type="checkbox"/> Wheeze <input type="checkbox"/> Chest Tightness <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Hospitalized <input type="checkbox"/> Intensive Care Triggers: <input type="checkbox"/> Seasonal <input type="checkbox"/> Year-round <input type="checkbox"/> Night-time <input type="checkbox"/> Morning <input type="checkbox"/> Weather Change <input type="checkbox"/> Grass <input type="checkbox"/> Molds <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Exercise <input type="checkbox"/> Aspirin <input type="checkbox"/> Fumes/Odors <input type="checkbox"/> Colds/Virus <input type="checkbox"/> Acid Reflux <input type="checkbox"/> Post-Nasal Drip <input type="checkbox"/> Other:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cough Patterns/Triggers: <input type="checkbox"/> Seasonal <input type="checkbox"/> Year-round <input type="checkbox"/> Night-time <input type="checkbox"/> Morning <input type="checkbox"/> All Day <input type="checkbox"/> Productive (mucous) <input type="checkbox"/> Unproductive (dry) <input type="checkbox"/> Weather Change <input type="checkbox"/> Grass <input type="checkbox"/> Molds <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Exercise <input type="checkbox"/> Aspirin <input type="checkbox"/> Fumes/Pollution/Odors <input type="checkbox"/> Acid-Reflux <input type="checkbox"/> Post-Nasal Drip <input type="checkbox"/> Colds/Viruses
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other breathing problems or lung conditions Describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sinus trouble or infections <input type="checkbox"/> Seasonal <input type="checkbox"/> Year-round <input type="checkbox"/> Sinus surgery? Date(s):
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent pneumonia Describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Immunodeficiency Describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hives or Swelling (urticaria or angioedema) Date Onset: _____ Frequency: _____ Describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eczema, contact dermatitis or recurrent rashes Date Onset: _____ Frequency: _____ Describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Eosinophilic Esophagitis Describe:
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stinging Insect Allergy <input type="checkbox"/> Honey Bee <input type="checkbox"/> Wasp <input type="checkbox"/> Other vespids <input type="checkbox"/> Fire Ant <input type="checkbox"/> Unsure <input type="checkbox"/> Swelling at sting site <input type="checkbox"/> Hives <input type="checkbox"/> Anaphylaxis
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Food Allergy Which foods: _____ Reactions/History: <input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Vomiting <input type="checkbox"/> Stomach Discomfort <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> ER?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Drug Allergy Which drugs: _____ Reactions/History: <input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Vomiting <input type="checkbox"/> Stomach Discomfort <input type="checkbox"/> Anaphylaxis <input type="checkbox"/> ER?
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other Allergic Concern(s) Describe:

ENVIRONMENTAL HISTORY	
Home	Type of residence: <input type="checkbox"/> House <input type="checkbox"/> Apartment/Condo <input type="checkbox"/> Mobile Home <input type="checkbox"/> Other: _____ Year built: _____
	Neighborhood: <input type="checkbox"/> Urban <input type="checkbox"/> Suburban <input type="checkbox"/> Rural <input type="checkbox"/> Woods <input type="checkbox"/> Farmland <input type="checkbox"/> Other: _____
	Any smokers in the house? <input type="checkbox"/> No <input type="checkbox"/> Yes, who: _____ <input type="checkbox"/> Smokes indoors <input type="checkbox"/> Outdoor only
	Basement? <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> Unfinished <input type="checkbox"/> Finished <input type="checkbox"/> Partially finished <input type="checkbox"/> Dry <input type="checkbox"/> Wet/Damp
	HVAC: <input type="checkbox"/> Forced air/heating <input type="checkbox"/> Central air <input type="checkbox"/> Wall/window/portable unit Do you use HEPA air filters? <input type="checkbox"/> No <input type="checkbox"/> Yes: <input type="checkbox"/> On central HVAC <input type="checkbox"/> Portable unit <input type="checkbox"/> Other air cleaner: _____
	Bedroom floor: <input type="checkbox"/> Carpet (Age: _____) <input type="checkbox"/> Wood/hard surface Area rug(s)? <input type="checkbox"/> No <input type="checkbox"/> Yes, age: _____
	Mattress: Type: <input type="checkbox"/> Spring <input type="checkbox"/> Foam <input type="checkbox"/> Hybrid <input type="checkbox"/> Air <input type="checkbox"/> Water <input type="checkbox"/> Other Age: _____ Dust-mite covers? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Pillow: <input type="checkbox"/> Feather <input type="checkbox"/> Synthetic <input type="checkbox"/> Foam <input type="checkbox"/> Other: _____ Age: _____ Dust-mite covers? <input type="checkbox"/> No <input type="checkbox"/> Yes
	Pets: <input type="checkbox"/> None <input type="checkbox"/> Dog(s) #: _____ Breed(s): _____ <input type="checkbox"/> Indoor only <input type="checkbox"/> Outdoor only <input type="checkbox"/> Indoor/Outdoor <input type="checkbox"/> Allowed in/sleeps in bedroom <input type="checkbox"/> Cat(s) #: _____ <input type="checkbox"/> Indoor only <input type="checkbox"/> Outdoor only <input type="checkbox"/> Indoor/Outdoor <input type="checkbox"/> Allowed in/sleeps in bedroom <input type="checkbox"/> Other pets: _____ <input type="checkbox"/> Indoor only <input type="checkbox"/> Outdoor only <input type="checkbox"/> Indoor/Outdoor <input type="checkbox"/> Allowed in/sleeps in bedroom Do you experience allergic symptoms when exposed to pets? <input type="checkbox"/> No <input type="checkbox"/> Yes, describe: _____
	Work / School
<input type="checkbox"/> Work: Your occupation: _____ Spouse's occupation: _____ If a dependent, occupation of: Father: _____ Mother: _____ Guardian: _____	
Number of missed school/work days in past year due to illness: _____	
Self	Hobbies/Activities: _____

OTHER HEALTH PROBLEMS / REVIEW OF SYSTEMS					
Check if you have, or have had any symptoms in the following areas to a significant degree. Check N/A if none/not applicable.					
N/A			N/A		
<input type="checkbox"/>	SKIN	<input type="checkbox"/> Hives <input type="checkbox"/> Eczema <input type="checkbox"/> Rash <input type="checkbox"/> Itching	<input type="checkbox"/>	ENDOCRINE	<input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid disease
<input type="checkbox"/>	EYES	<input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataract <input type="checkbox"/> Discharge <input type="checkbox"/> Itching <input type="checkbox"/> Pain <input type="checkbox"/> Visual impairment <input type="checkbox"/> Contact lenses	<input type="checkbox"/>	GASTROINTESTINAL	<input type="checkbox"/> Acid reflux <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Difficulty swallowing
<input type="checkbox"/>	EARS	<input type="checkbox"/> Hearing loss <input type="checkbox"/> Pain/Ache <input type="checkbox"/> Itching <input type="checkbox"/> Pressure <input type="checkbox"/> Ringing <input type="checkbox"/> Popping <input type="checkbox"/> Dizziness <input type="checkbox"/> Infection	<input type="checkbox"/>	GENITOURINARY	<input type="checkbox"/> Frequent/difficult urination <input type="checkbox"/> Frequent UTIs <input type="checkbox"/> Prostate problems
<input type="checkbox"/>	NOSE/SINUS	<input type="checkbox"/> Stuffy <input type="checkbox"/> Runny <input type="checkbox"/> Sneezing <input type="checkbox"/> Drainage <input type="checkbox"/> Polyps <input type="checkbox"/> Headache <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Loss of smell or taste	<input type="checkbox"/>	IMMUNOLOGIC	<input type="checkbox"/> Frequent sinusitis <input type="checkbox"/> Immunodeficiency <input type="checkbox"/> Frequent bronchial infections
<input type="checkbox"/>	MOUTH/THROAT	<input type="checkbox"/> Pain <input type="checkbox"/> Itching <input type="checkbox"/> Hoarseness <input type="checkbox"/> Mouth sores	<input type="checkbox"/>	NEUROLOGIC	<input type="checkbox"/> Dizziness <input type="checkbox"/> Headache
<input type="checkbox"/>	LUNGS	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Mucus production <input type="checkbox"/> Wheeze <input type="checkbox"/> Cough up blood	<input type="checkbox"/>	PSYCHIATRIC	<input type="checkbox"/> Anxiety <input type="checkbox"/> Depression
<input type="checkbox"/>	CHEST/HEART	<input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> High blood pressure	<input type="checkbox"/>	CONSTITUTIONAL	<input type="checkbox"/> Fever <input type="checkbox"/> Weight change <input type="checkbox"/> Appetite change
<input type="checkbox"/>	BLOOD	<input type="checkbox"/> Bruise easily <input type="checkbox"/> Bleed easily <input type="checkbox"/> Clotting disorder	<input type="checkbox"/>	SLEEP	<input type="checkbox"/> Insomnia <input type="checkbox"/> Snoring <input type="checkbox"/> Apnea
<input type="checkbox"/>	MUSCULOSKELETAL	<input type="checkbox"/> Joint pain <input type="checkbox"/> Back pain <input type="checkbox"/> Arthritis <input type="checkbox"/> Osteoporosis	<input type="checkbox"/>	OTHER	

Is there anything else you would like to discuss? 	Patient/parent signature _____ Date _____
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Additional physician notes:

Initial assessment reviewed by physician

Physician Signature

Date