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

Name:___________________________________DOB__________ Visit Date___________

Referred to our office by:____

Main Reason for Visit:____

Other Allergic Conditions (Please Circle those that apply):

Nasal and/or Eye Allergies
Hives
Food Allergy
Eczema and/or Rash
Asthma and/or Cough
Other:__________________

Aggravated by: ☐ Nothing

Yes	No		Yes	No	
☐	☐	cat	☐	☐	pollen
☐	☐	cold air	☐	☐	respiratory infections
☐	☐	dog	☐	☐	smoke
☐	☐	dust	☐	☐	stress
☐	☐	exercise	☐	☐	weather changes
☐	☐	food	☐	☐	winter
☐	☐	infection	☐	☐	spring
☐	☐	mold	☐	☐	summer
☐	☐	nasal decongestant spray	☐	☐	fall
☐	☐	odors			

Timing:

☐ morning
☐ evening
☐ bedtime
☐ lying down
☐ on wakening
☐ night worsening
☐ other:__________________

☐ at home
☐ at work/school
☐ inside
☐ outside
☐ with URI’s
☐ with weather changes

☐ seasonally
☐ winter
☐ spring
☐ summer
☐ fall
☐ year round

Severity: ☐ mild ☐ moderate ☐ severe ☐ incapacitating

Status (Currently): ☐ improved ☐ no change ☐ worsened

Frequency: ☐ intermittent ☐ persistent ☐ occasional

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

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

Eyes/Ears/Nose/Throat:
Trouble swallowing
Ear infections
Eye redness
Headache
Hearing loss
Hoarseness
Itchy eyes
Nasal congestion
Ear pain
Sore throat
Post nasal drip
Runny nose
Sneezing
Tearing

Respiratory:
Rapid breathing
Cough
Trouble breathing
Coughing up blood
sharp, painful breathing
Coughing up sputum
Tight throat
Extra muscles to breathe
Wheezing
Frequent colds
Known TB exposure

Stomach/Intestines:
Abdominal pain
Bloating
Blood in stool
Constipation
Diarrhea
Heartburn
Nausea
Pain with swallowing
Reflux
Vomiting

Metabolic/Endocrinology:
Abnormal sleep pattern
Cold intolerance
Neck/thyroid swelling
Heat intolerance
Increased activity

Hematology:
Easy bruising
Swollen glands

Heart:
Chest pain
Trouble breathing at night
Trouble breathing on lying down
Irregular heartbeat

Bee Sting:
Bee sting allergy

Neuro/Psych:
Appropriate interaction
Dizziness
Off balance
Light-headed
Sense of room spinning

Skin:
Rash after touching things/plants
Frequent skin infections
Itchiness
Rash present

Musculoskeletal:
back pain
bone/joint symptoms
muscle weakness
muscle ache/pain

Vascular:
Swelling
Areas of body turn blue/purple/pale explain_________________________
Pain in legs with walking
Blood clots in veins

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
☐Diabetes
☐Gallbladder disease
☐Heartburn
☐Hepatitis A
☐Hepatitis B
☐Hepatitis C
☐High blood pressure
☐High cholesterol
☐Irritable bowel
☐Liver disease
☐Migraine headache
☐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
☐Colectomy
☐Colostomy
☐Gastric bypass
☐Hernia repair
☐LASIK
☐Ear tubes
☐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 biopsy
☐Prostate removal
☐vasectomy
☐other____

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)
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________
________________________	____________________	____________________

Please provide the name and location of your preferred pharmacy:

____

Family History

❐Check if Adopted

	MOTHER	FATHER	SISTER	BROTHER	CHILDREN	OTHER RELATIVE
nasal or eye allergies						
asthma						
eczema						
Recurrent sinus or lung infection						
COPD, emphysema or cystic fibrosis						
smoker						
Food allergies						
Other significant illnesses						

Homeopathic/Herbal/Complimentary/Alternative treatments:____

Drug Allergies____

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)____
Occupation____

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) ___________________________________
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) ____
Kept Inside ❒yes ❒no
Kept in Bedroom ❒yes ❒no

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.