Allergy & Asthma Associates of Southern California
Leading-edge, personalized care you can trust

27800 Medical Center Road, Suite 244 • Mission Viejo, CA 92691
15785 Laguna Canyon Road, Suite 100 • Irvine, CA 92618
Tel: (949) 364-2900 • Fax: (949) 365-0117
www.SoCalAllergy.com

Warner W. Carr, M.D. **Mark S. Sugar, M.D.**
Diplomates of the American Board of Allergy and Immunology

PATIENT NAME:_____ **TODAY'S DATE:**_____
DATE OF BIRTH:_____ **SEX: M F AGE:**_____
EMAIL ADDRESS:_____ **PHONE:**_____
REFERRED BY:_____ **PCP:**_____

INSTRUCTIONS FOR COMPLETING HEALTH QUESTIONNAIRE: If you are unable to complete this form online or prefer to fill out a hard copy, please print and complete this document, bringing it with you when you arrive for your first appointment. This form is designed to help find the cause of your problem and is an essential part of your evaluation, aiding in the proper selection of tests and treatments, and allowing us to spend more time focusing on your important problems. When possible, please provide a start and stop date for all medical conditions as well as provide a check box in the Med Taken box if you are currently taking medication for that condition. If you have a condition that is not listed please add it in the OTHER section.

****PLEASE NOTE: No antihistamines, such as Claritin, Allegra, Zyrtec, or Benadryl for at <u>least 72 hours</u> before your appointment, as they interfere with allergy testing. Asthma medications are allowed if needed for wheezing and coughing. If you are unsure of any medication you are presently taking, please call our office for instructions. ****

CHIEF COMPLAINT: (The main reason you are here)

_____

_____

HISTORY OF PRESENT ILLNESS (Please provide a brief description of your current condition)

_____

_____

_____

_____

_____

Please List All Current Medications	Dosages

PATIENT NAME:_____ DOB:_____

Please indicate if you have **EVER** been diagnosed with any of the medical conditions listed below

Allergies

☐ Hayfever or Allergic Rhinitis (Stuffy, Runny, Itchy Nose, Sneezing)

Symptoms Worse: ☐ Indoors ☐ Outdoors ☐ Both

☐ Allergic Conjunctivitis (Red, Itchy Eyes)

☐ Food Allergy

List Each Food and Reaction:

_____

_____

_____

☐ Stinging Insect Allergy (Bee, Wasp, Hornet, Etc.)?_____

☐ Drug Allergies

List Each Drug and Reaction:

_____

_____

Eyes, Ears, Nose & Throat

☐ Sinus Infections ☐ Ear Infections

☐ Nasal Polyps ☐ Hearing Loss

☐ Bloody Nose ☐ Cataracts

☐ Tubes in Ears ☐ Glaucoma

Lungs/Pulmonary

☐ Asthma

If yes: □ Have you ever used oral steroids for Asthma/COPD?

Date:_____

☐ Have you ever been hospitalized Asthma/COPD?

Date:_____

☐ # of ER visits in the past year for Asthma/COPD #_____

☐ How many times per week do you use your rescue medication?

#:_____

☐ Pneumonia Date:_____ □ Pulmonary Embolism Date: _____

☐ Smoking Packs/Day____ Yrs of Smoking:_____ Date Quit:_____

Skin/Dermatologic

☐ Eczema ☐ Hives Other Rash:_____

Endocrine

☐ Diabetes ☐ Thyroid Disease

☐ Other Endocrine Problems:_____

Heart/Cardiovascular

☐ High Blood Pressure ☐ High Cholesterol

☐ Heart Attack ☐ Heart Murmur

☐ Angina or Chest Pain ☐ Arrhythmias

Digestive/Gastrointestinal

☐ Ulcer ☐ Irritable Bowel

☐ Acid Reflux or Heartburn ☐ Diarrhea

☐ Nausea or Vomitting ☐ Hepatitis

Genitourinary/Gynecological

☐ Urinary Tract Infections ☐ Genital Herpes

☐ Enlarged Prostate ☐ Hysterectomy

☐ Menopause

Rheumatologic

☐ Osteoarthritis ☐ Rheumatoid Arthritis

☐ Osteoporosis ☐ Other:_____

Neurologic

☐ Migraine Headaches ☐ Sinus Headaches

☐ Stroke ☐ Seizures

☐ Other Neurologic Disorder:_____

Psychiatric

☐ Depression ☐ Anxiety

☐ Bipolar Disorder ☐ ADD/ADHD

☐ Other Psychiatric Disorder:_____

Other Chronic Medical Conditions:

PATIENT NAME:_____ DOB:_____

Cancer (Please specify type):

Surgical Procedures (List any previous surgeries and dates)

Previous Evaluation

☐ Allergy Tested Before? Date:_____

☐ Received Allergy Injections? Date:_____

☐ Pulmonary Function Testing? Date:_____

Medications that made your symptoms better:_____

Medications tried but did not help:_____

Family History (Check all that apply & the relationship)

☐ Hayfever? Relationship:_____

☐ Asthma? Relationship:_____

☐ Sinus Problems? Relationship:_____

☐ Eczema? Relationship:_____

☐ Bronchitis? Relationship:_____

☐ Emphysema? Relationship:_____

☐ Cystic Fibrosis? Relationship:_____

☐ Diabetes? Relationship:_____

☐ Heart Disease? Relationship:_____

Social History

School:_____ Grade:_____

Occupation:_____

Do you smoke? ☐ Yes ☐ No ☐ Quit

Packs Per Day?_____ How many years?_____

Exposed to second hand smoke? □ Yes □ No

Do you drink alchohol? ☐ Yes ☐ No ☐ Quit

How many drinks per week?_____

Do you drink caffeine (Coffee/Tea/Caffeinated Soda)? ☐ Yes ☐ No

Type:_____ Cups/Day:_____

Do you use any illicit drugs? ☐ Yes ☐ No ☐ Quit

Type:_____

Environmental

☐ Carpet ☐ Smokers in the home

☐ Pets (If yes, select type) ☐ Cat ☐ Dog ☐ Other:_____

Review of Systems

Please indicate any **Current** problems in the following areas:

General

☐ Chills ☐ Fever ☐ Weightloss ☐ Fatigue

Eyes

☐ Change in vision ☐ Itchy ☐ Red ☐ Watery

Ears

☐ Ear Infection ☐ Decreased Hearing ☐ Ear Popping

Nose

☐ Congestion ☐ Runny Nose ☐ Sneezing ☐ Itchy Nose

☐ Sinus Infection ☐ Post Nasal Drip ☐ Seasonal Allergies

Throat

☐ Sore Throat ☐ Change In Voice

Respiratory

☐ Shortness of Breath ☐ Cough ☐ Pain With Breathing

☐ Wheezing ☐ Problems with exercise

Cardiovascular

☐ Chest Pain ☐ Palpitations ☐ Arrythmias

☐ Leg Swelling

Gastrointestinal

☐ Abdominal Pain ☐ GERD or Acid Reflux ☐ Diarrhea

☐ Food Allergy

Reproductive

☐ Penile Discharge ☐ Vaginal Discharge □ Breast Pain

☐ Breast Lump □ Sexual Dysfunction

Skin

☐ Hives ☐ Red Rash ☐ Itchy Rash ☐ Contact Allergy

PATIENT NAME:_____ DOB:_____

Review of Systems (continued)

Neurologic ☐ Dizziness ☐ Headache ☐ Numbness ☐ Vertigo/Room Spinning **Musculoskeletal** ☐ Back Pain ☐ Joint Pain ☐ Muscle Aches	**Psychiatric** ☐ Anxiety ☐ Depression ☐ Increased Stress **Other (Please Describe):**

PLEASE NOTE: ALL INFORMATION SUBMITTED ON THIS FORM IS CONSIDERED SECURE HEALTHCARE INFORMATION AND IS HELD IN THE STRICTEST CONFIDENCE, PROTECTING YOUR RIGHTS TO PRIVACY.

QUESTIONNAIRRE COMPLETED BY:_____
RELATIONSHIP TO PATIENT:_____
DATE COMPLETED:_____

FOR OFFICE USE ONLY
This history form has been reviewed and discussed in detail with the patient.

Physician Signature	Date