

**Clinical Research Institute
Allergy / Asthma Medical History Form**

Please fill out this form as completely as possible and bring it to your first research study appointment.

Name: _____ DOB: _____ Today's Date: _____

Nasal(nose) Symptoms:

Date when nasal symptoms first started _____ Date when allergies were diagnosed _____

Put a check mark by any symptoms of the nose that you experience:

Itching Sneezing Stiffness Runny nose Yellow drainage Bleeding Loss of sense of smell
Comments _____

Is sleep disturbed by nasal congestion? No Yes _____
Do you have sinusitis? No Yes _____
Have you taken an antibiotic for sinus infections? No Yes _____
Have you had x-rays or CT scan of your sinuses? No Yes _____
Have you had surgery on your sinuses? No Yes-when? _____
Have you had nasal polyps? No Yes _____

Eye Symptoms: Put a check mark by any eye symptoms that you experience:

Itching Watering Redness Burning Dryness Loss of vision Eyelid swelling

Symptom Patterns: If you have symptoms of the nose or eyes, put a check next to the time of the year they occur:

Spring Summer Fall Winter Off and on all year

If you have symptoms of the nose or eyes circle any factors that make you feel worse:

*Animals House dust Musty odor Cold air/Food Being indoors Being outdoors Being at work Smoke
Temperature changes Dampness Raking leaves Lawn mowing Barns*

Have you ever had allergy skin testing? no yes –when and where? _____

Put a check mark next to what you are allergic to: dust mites mold tree pollen grass pollen ragweed pollen animals

Have you ever been on allergy shots? no yes- Date started _____ Date stopped _____

Chest Symptoms

Date when asthma/chest symptoms first started _____ Date when asthma was diagnosed _____

Circle symptoms: Shortness of breath Wheezing Cough Tight chest Other _____

Number of days per week you have chest symptoms: _____ Number of nights per week asthma disturbs sleep: _____

Have you ever :

Been in an emergency room for asthma? No Yes-when? _____
Been hospitalized for asthma? No Yes-when? _____
Had intensive care treatment for asthma? No Yes-when? _____
Taken steroid pills or shots for asthma? No Yes- How many times? _____
Had an abnormal chest x-ray? No Yes-when? _____
Had pneumonia? No Yes-when? _____
Date of last chest x-ray: _____

Pattern of Asthma:

Check which season(s) asthma symptoms are most frequent: Spring Summer Fall Winter All year

What time of day are asthma symptoms most frequent: Morning Afternoon Evening Nighttime

Circle the factors which make your asthma worse:

Animals House dust Smoke Cold air Foods Exercise Infections Colds Medication reactions

Food Allergy: Check symptoms that happen after you eat a food you're allergic to:

Hives Itchy mouth Swollen throat Vomiting Diarrhea Asthma Nasal Congestion Shock

Which foods cause this: _____

Social History:

Do you or did you smoke tobacco? No Yes – what type (circle) Cigarettes Pipe Cigars Chew tobacco? No Yes

How many years did you or have you smoked? _____ If no longer smoking, date stopped _____

If cigarettes, how many packs per day do you or did you smoke? _____

How many alcoholic beverages do you have per week? _____ Per day? _____

Drug Allergy: No Yes

Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other _____

Name of drug: _____ Circle reaction: Hives Rash Itching Asthma Shock Other _____

Please tell us if you currently have or have had a past history of any of the following conditions.

If you answer yes, please circle condition and give dates that the condition started, stopped or if it is continuing.

Head/Ears/Eyes	Problems with your eyes, ears or throat?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Nose/Throat	Speech or hearing problems?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Headaches (cluster, tension, migraines) or seizures?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Sinus problems (loss of smell, polyps, infection)?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Mouth/throat problems (infections, hoarseness)	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Problems with vision?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Emotional:	Do you feel nervous, angry, suicidal, depressed, lonely, sad or out of control?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Do you have trouble sleeping?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Endocrine:	Diagnosed with diabetes? When/type _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Do you have thyroid disease?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Cataracts?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Circulatory:	Heart problems (high blood pressure, palpitations, chest pain, irregular heart beat)?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Respiratory:	Lung problems (bronchitis, pneumonia, TB, emphysema)?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Gastrointestinal:	Recent problems with eating, drinking?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Problems with nausea, vomiting, abdominal pain, or bloody stools?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Recent weight changes or change in appetite within the last 3 months?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Ulcers, hernias, indigestion, cirrhosis, or hepatitis?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Genital/Urinary:	Burning, pain or frequency when urinating?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Have you been treated for a sexually transmitted disease? If yes, what _____	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Have you had kidney stones, prostate infection (male), or urinary tract (bladder) infection?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Immune:	Cancer, blood diseases, deficiencies, anemia?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
Mobility:	Muscular/joint (i.e. arthritis) bone/orthopedic problems or difficulty with coordination?	<input type="checkbox"/> No <input type="checkbox"/> Yes _____
	Skin:	Problems with your skin (rash, hives, changes in skin/hair, cold sores, eczema)?

Have you ever had surgery? ___ No ___ Yes – Date and type of surgery.

Have you ever been hospitalized other than for a surgery? ___ No ___ Yes - Describe _____

MEDICATIONS –list all medications (including prescription and over-the-counter) used in the past 6 months.

<u>Medication</u>	<u>Dose</u>	<u>Reason for use</u>	<u>Date started</u>	<u>Date stopped</u>
(example) ibuprofen	2-200 mg tabs	tension headache	April 1, 2009	April 2, 2009
