New Patient Medical History Form
Allergy and Asthma Specialists
Dr. Carol Fosso, M.D.

Name_____ DOB _____ Age _____Date_____

Chief Complaint (Why are you seeing the doctor?) _____

_____

_____

Part 1. Symptoms

Eyes and Ears

Itchy & Watery Eyes	☐	Swelling around Eyes	☐	Ear Infections	☐
Red Eyes	☐	Light Hurts Eyes	☐	Decreased Hearing	☐

Nose and Sinuses

Stuffy	☐	Decreased Smell	☐	Post Nasal Drainage	☐
Runny	☐	Frequent Colds	☐	Mouth Breathing	☐
Itchy	☐	Nosebleeds	☐	Nose Spray Use	☐
Sneezing	☐	Nasal Polyps	☐	Sinus Headaches	☐

Throat and Lungs

Sore Throat	☐	Wheezing	☐	Lung Infections	☐
Throat Infections	☐	Coughing	☐		
Tonsillitis	☐	Shortness of Breath	☐		

Skin

Hives	☐	Eczema	☐

Symptoms have been worse for_____

Part 2. Variation of Symptoms.

Do your symptoms occur:

☐ Daily ☐ 3-4x a week ☐ 1-2x a week ☐ less than 1x weekly

Do you have trouble sleeping at night due to symptoms? ☐ Yes ☐ No

On the weekends, are your symptoms: ☐ Better ☐ Worse ☐ No Difference

Are your symptoms worse during specific times of the day?

☐ Morning ☐ Evening ☐ Bedtime ☐ No Difference

Are your symptoms worse during any season?

☐ Spring ☐ Summer ☐ Fall ☐ Winter

Check which month(s) in which nasal symptoms occur:

Jan. ☐	Feb. ☐	Mar. ☐	April. ☐	May. ☐	Jun. ☐
Jul. ☐	Aug. ☐	Sept. ☐	Oct. ☐	Nov. ☐	Dec ☐

Check which month(s) in which eye symptoms occur:

Jan. ☐	Feb. ☐	Mar. ☐	April. ☐	May. ☐	Jun. ☐
Jul. ☐	Aug. ☐	Sept. ☐	Oct. ☐	Nov. ☐	Dec ☐

Check which month(s) in which throat and lung symptoms occur:

Jan. ☐	Feb. ☐	Mar. ☐	April. ☐	May. ☐	Jun. ☐
Jul. ☐	Aug. ☐	Sept. ☐	Oct. ☐	Nov. ☐	Dec ☐

Part 3. Precipitation Factors.

Which of these make your symptoms worse? Please Circle.

Sweeping or dusting	Dogs	Dampness/Humidity
Vacuuming	Horses	Temperature Changes
Making the Bed	Other Animals	Heat
Shaking Rugs	Birds	Cold Air
Contact with Old Furniture	Feather Pillows	Drafts/Wind
Basement	Cigarette Smoke	Exertion
Mowing Grass	Perfumes/Deodorant	Laughing/Coughing
Hay or Straw	Insect Spray	Respiratory Infections
Raking Leaves	Paint	Colds
Cottages or Cabins	Hair Spray	Emotional Upsets
Moldy or Musty Areas	Enzyme Detergents	Menses
Cats	Air Pollution	Fatigue

Part 4. Previous Allergy Evaluation and Treatment.

Please check what applies to you.

Have you had allergy skin tests or blood tests? ☐ Yes ☐ No

Did the results of these tests indicate that you were allergic to:

☐ Pollen ☐ Dust ☐ Dust Mites ☐ Pets ☐ Mold ☐ Others

Have you received allergy shots or immunotherapy? ☐ Yes ☐ No

If yes, when did you receive these shots or treatments?

From age_____ until age _____.

Was there any improvement in your symptoms after receiving injections? ☐ Yes ☐ No

Did you have any bad reactions to allergy injections? ☐ Yes ☐ No

If yes, then please explain. _____

_____

_____

Part 5. Past Medical History

Medication List

Medication Name	Dose	Times per Day

Allergy and Asthma Medications used in the past

_____

_____

_____

Please check what applies to you and explain what applies to you.

Have you had any allergic reactions or any type of bad reactions to any medications?

☐ ☐

Yes No

If yes, which medications caused these reactions? _____

_____

Do any foods or beverages bother you? (cause cramps, rash, swelling, itching, make other symptoms worse, etc.)

☐ Yes ☐ No

If yes, which foods or beverages cause these reactions? _____

_____

Have you ever had a bad reaction to a bee, wasp, or yellow jacket sting?

☐ Yes ☐ No

If yes, then please explain. _____

_____

Other Medical Illnesses

Please list any medical illnesses or conditions that are not included in the previous sections.

_____

_____

_____

Surgeries

Please list any surgeries you have had.

_____

_____

_____

Hospitalizations

Please list the reason for any hospitalizations you have had and their approximate date.

_____

_____

_____

Part 6. Family History

Please check what applies to each family member.

	Asthma	Hay Fever	Eczema	Hives	Sinus
Mother					
Father					
Brother					
Sister					
Children					
Aunt					
Uncle					
Grand Mother					
Grand Father					

Part 7. Social History

Please check what applies to you, and fill in the blanks where needed.

What is your line of work?_____

Have you ever worked around:

Rubber or Latex ☐	Asbestos ☐	Moldy Hay or Grain ☐
Pigeons or Parakeets ☐	Plastics/Acrylics ☐	Steel Mill ☐
Beryllium ☐	Sand Blasting ☐	Welding Arc ☐
Detergent Factory ☐	Meat Wrappers ☐	Sugar Cane Fields ☐
A Mine or Quarry ☐		

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Are your symptoms worse at work? ☐ Yes ☐ No

Marital Status: ☐ Married ☐ Single ☐ Divorced

Do you now, or did you ever smoke? ☐ Yes ☐ No

If yes, how much and what did you smoke per day? _____

_____

How many years did you smoke? _____

Are you exposed to second hand smoke? ☐ Yes ☐ No

If yes, where? _____

How much alcohol do you drink? _____

What is your recreational drug use? _____

Part 8. Environmental History

Residence Type

House ☐	Apartment ☐	Other ☐

Hold old is your present home? _____

In what area is your home located?

Urban ☐	Suburban ☐	Rural ☐
Heavily Wooded ☐	Industrial ☐	

Heating System

Forced Air ☐	Steam ☐	Hot Water ☐
Space Heater ☐	Electric Radiant Coils ☐	None ☐

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Air Conditioning

None ☐	Central ☐	Room ☐

Humidifier

None ☐	Central ☐	Room ☐

Does you home have a basement? ☐ Yes ☐ No

If yes, is it musty smelling? ☐ Yes ☐ No

How many beds are in your bedroom? _____

Mattress Type

Inner Spring ☐	Cotton Felt ☐	Feather ☐	Foam ☐

Pillow Type

Foam ☐	Dacron ☐	Cotton ☐	Feather ☐

Do you have any of the following in your bedroom?

Bookcase ☐	Stuffed Toys ☐	Upholstered Furniture ☐
Pets ☐	House Plants ☐	

Bedroom Flooring Type

Wall to Wall Carpeting ☐	Hardwood ☐	Linoleum/Vinyl ☐

Part 9. For Women of Childbearing Age

What is your birth control method? _____

Are you Pregnant? ☐ Yes ☐ No

You plan a pregnancy in _____ years

Part 10. Review of Systems

Please check any symptoms or problems you have.

Constitutional Symptoms

Fatigue ☐	Poor Appetite ☐	Weakness ☐	Weight Loss ☐
Weight Gain ☐	Fever ☐	Chills ☐	Night Sweats ☐

Eyes

Cataracts ☐	Blurry Vision ☐	Glaucoma ☐	Eye Pain ☐

Ears, Nose, Mouth, and Throat

Ear-Aches ☐	Ringing in Ears ☐	Broken Nose ☐	Hoarseness ☐
Decreased Hearing ☐	Soreness in Mouth ☐	Neck Pain ☐	

Pulmonary

Pneumonia ☐	Bronchitis ☐	Coughing Blood ☐	Tuberculosis ☐

Date of last chest x-ray _____

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Cardiovascular

Chest Pain ☐	Heart Murmur ☐	Irregular Rhythm ☐
Swelling of Legs ☐	Palpitations ☐	Blood Clots ☐
High Blood Pressure ☐	Easy Bruising ☐	Heart Failure ☐

Gastrointestinal

Heartburn ☐	Acid Regurgitation ☐	Choking ☐
Difficulty Swallowing ☐	Reflux ☐	Hiatal Hernia ☐
Ulcer ☐	Diarrhea ☐	Liver Disease ☐
Nausea/Vomiting ☐		

Genitourinary

Bladder Infections ☐	Urinal Tract Infections ☐	Kidney Trouble ☐
Yeast Infections ☐	Menstrual Abnormalities ☐	

Endocrine

Diabetes ☐	Thyroid Disease ☐	Heat Intolerance ☐

Musculoskeletal

Joint Pain ☐	Muscle Pain ☐	Back Pain ☐
Arthritis/Gout ☐	Osteoporosis ☐	

Skin and/or Breast

Rashes ☐	Swelling ☐	Infections ☐
Athlete's Foot ☐	Varicose Veins ☐	

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Neurological

Headaches ☐	Dizziness ☐	Vertigo ☐
Numbness ☐	Seizures ☐	Weakness of Limbs ☐

Psychiatric

Depression ☐	Anxiety ☐	Mood Swings ☐
Trouble Sleeping ☐	Stress ☐	

Allergic/Immunologic

Hay Fever ☐	Asthma ☐	Sinus Infections ☐
Food Allergies ☐	Frequent Infections ☐	

Please have your primary care doctor fax or send recent blood tests and x-ray results to our office.

Add any additional comments you would like to make regarding your problem.

_____

_____

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