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ASTHMA AND ALLERGY CONSOLATION(ADULT)

Name: _____ Date: _____

Age: _____ Date of Birth: _____ Referred by: _____

Current Physician: _____

What health problems are you having? What would you like to learn and what changes would you like to see for yourself as a result of this consultation?

Current Medication			Drug Allergies	Reaction
Drug	Dose	How Often		
			Food Allergy	Reaction

Over the Counter medication, nose sprays or vitamins, not mentioned above?

_____

FAMILY HISTORY: (Note: Allergy & Asthma Problems)

	Age:	Health Status
Father		
Mother		
Sibling		

Children	**Age**	**Health Status**

Any on-going significant illness for you? _____

SMOKING HISTORY: ☐None ☐Cigarettes ☐ Cigars ☐Pipe ☐Chewing tobacco ☐Live with smoker
No. of years_____ Packs per Day_____ Cigarettes per day_____ Quit _____

Pets: ☐ Dog(s) ☐Cat(s) ☐Reptile(s) ☐Fish ☐ Rodents ☐Bird(s) ☐Others

Personal Medical History: ☐High blood pressure ☐Heart disease ☐Heartburn/Ulcers
☐Diabetes ☐Stroke ☐Gastric reflux ☐Others _____

Past Surgeries	**Year**	**Hospitalizations**	**Years**

ER/Urgent Care Visits for what and when? _____

Number of work misses in the past twelve months. _____
Number of Emergency visits for asthma or respiratory distress in the past? _____

Did you have: Influenza Vaccine: ☐**Yes year**_____ ☐**No**
Pneumonia Vaccine ☐**Yes year**_____ ☐**No**

HOBBIE/INTERESTS:

YOUR SKIN: ☐Dry Skin ☐Hives ☐Eczema ☐Psoriasis ☐ Other_____

YOUR EARS: ☐ Frequent ear infections ☐ Tubes ☐Hearing loss ☐Hearing aids ☐Other_____

YOUR NOSE (check all that pertain) **Date of last CT of the sinuses if any:**_____

☐ Seasonal symptoms ☐Symptoms worse in the morning? ☐Snores
☐ Year-round symptoms ☐Mouth breather ☐Frequently sneezes
☐ Nasal polyps ☐ Symptoms with pet exposure ☐ Other

Age of onset of allergy, wheezing, or chronic cough? _____

Number of episodes of asthma (any asthma problems which cause you to modify your activity or take different medications)

_____times per year _____times per month _____per week ____time per Season

ASTHMA or ALLERGY TRIGGERS: Activities or substance that bring on symptoms

☐ Respiratory infections ☐ Cats ☐ Morning cough ☐ Pollen ☐ Molds ☐ Cold air
☐ Pollutants ☐ Dogs ☐ Nighttime cough ☐ Perfumes ☐ Smoke ☐ Exercise
☐ Other_____

Do Symptoms get worse at certain time of year?

☐ Spring ☐ Summer ☐ Fall ☐ Winter

ASTHMA HISTORY

Do you HAVE:	**In the past month(circle that applies**			
Wheezing	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Coughing	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Shortness of breath	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Rapid Breathing	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Chest tightness	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Chest Pian	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Throat clearing	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Difficulty breathing in	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Coughing at night	**No**	**<2 times a week**	**>2 times a week**	**Daily**
Rescue medication	**No**	**<2 times a week**	**>2 times a week**	**Daily**

Steroid use: ☐ No ☐ This week ☐ This month ☐ Last month ☐ This year ☐ Last year

Do you use an Aerochamber for your medicine? ☐ **Yes** ☐ **No**

Living Environment: ☐ House (age of house___) ☐ Apartment ☐ Trailor ☐ City ☐ Rural

Type of Heat: ☐ Gas forced air ☐ Electric ☐ Wood burning
☐ Steam ☐ Oil ☐ Humidifier Central/Room

Air Conditioning: ☐ None ☐ Central ☐ Room ☐ Dehumidifier

Bedroom: **Bed** ☐ Conventional Mattress ☐ Waterbed ☐ _____

Pillow ☐ Polyester fill pillow ☐ Foam ☐ Down

Flooring: ☐ Carpet ☐ Hardwood ☐ Linoleum ☐ Vinyl

Basement: ☐ None ☐ Partial ☐ Full ☐ Damp

Is there anything else you would like us to know?