



**PAST MEDICAL HISTORY**

<b>EARS, EYES, NOSE, AND THROAT</b>	Date Symptoms started or Diagnosed	CHECK IF CURRENT	<b>CARDIOVASCULAR</b>	Date Symptoms started or Diagnosed	CHECK IF CURRENT
Allergies Y N			Chest pain/ Angina Y N		
Seasonal / Yr Round (circle one)			Heart Attack Y N		
Impaired Hearing Y N			Hypertension Y N		
Chronic Sinusitis Y N			Heart Murmur Y N		
Glasses/Contacts Y N			Mitral Valve Prolapse Y N		
Farsighted / Nearsighted (circle one)			Phlebitis Y N		
Glaucoma Y N			High Cholesterol Y N		
Cataracts Y N			<b>GASTROINTESTINAL</b>		
<b>RESPIRATORY</b>			Gastric ulcer Y N		
Asthma Y N			Duodenal ulcer Y N		
Bronchitis Y N			Gall bladder disease Y N		
Pneumonia Y N			Constipation Y N		
COPD Y N			Hemorrhoids Y N		
<b>GENITOURINARY</b>			Diarrhea Y N		
Enlarged Prostate Y N			Heartburn/Indigestion Y N		
Frequent bladder infections Y N			Esophageal Stricture Y N		
Kidney disease Y N			<b>NEUROPSYCHIATRIC</b>		
<b>HEMATOLOGICAL</b>			Depression Y N		
Blood disorders Y N			Convulsions/Seizures Y N		
Anemia Y N			Stroke Y N		
<b>DERMATOLOGICAL</b>			Paralysis Y N		
Eczema/Atopic Dermatitis Y N			Migraines/Headaches Y N		
Psoriasis Y N			<b>ALLERGIES</b>		
Acne Y N			Drug Allergies Y N		
<b>MUSCULOSKELETAL</b>			Food Allergies Y N		
Carpal Tunnel Syndrome Y N			<b>IMMUNOLOGICAL</b>		
Arthritis Y N			HIV Y N		
Broken Bones (specify) Y N			Hepatitis (specify) Y N		
<b>GYNECOLOGICAL</b>			<b>OTHER</b>		
Ovarian Cysts/Tumors Y N			1)		
Uterine Cysts/Tumors Y N			2)		
<b>ENDOCRINE</b>					
Diabetes Y N					
Thyroid Y N					

**SURGERIES AND PROCEDURES or ! None**

<u>Procedures</u>	<u>Date</u>		<u>Procedures</u>	<u>Date</u>

**HOSPITALIZATION or ! None**

<u>Date</u>	<u>Reason</u>	<u>Location</u>



<b>FAMILY HISTORY</b>	HAYFEVER OR NASAL SYMPTOMS	SINUS	ASTHMA	CHRONIC LUNG DISEASE OR EMPHYSEMA	FOOD ALLERGY	HIVES OR SWELLING	ECZEMA
MOTHER	!	!	!	!	!	!	!
FATHER	!	!	!	!	!	!	!
BROTHERS/SISTERS	!	!	!	!	!	!	!
CHILDREN	!	!	!	!	!	!	!
ARE THERE GRANDPARENTS, AUNTS OR UNCLAS WITH ALLERGY PROBLEMS?		! NO <i>IF YES, EXPLAIN</i> ! YES					
<b>CHECK OR COMPLETE THE ANSWERS THAT BEST DESCRIBE YOUR HOME ENVIRONMENT</b>							
TYPE OF HOME		LOCATION OF HOME			IS THERE OBVIOUS?		
! APARTMENT ! DORMITORY		! SEASHORE ! MOUNTAIN ! CITY			! MILDEW OR WATER DAMAGE		
! MOBILEHOME ! HOUSE ! CONDOMINIUM		! COUNTRYSIDE ! DESERT			! ROACHES		
INDICATE INDOOR PETS YOU HAVE		BEDROOM HAS: ! HEATING ! HUMIDIFIER					
! CAT ! DOG ! BIRD ! OTHER		! AIR PURIFIER ! AIR CONDITIONING					
Type of bedroom floor covering:				Type of Pillows you have:		Age of pillow in years: _____	
! Carpet ! Linoleum or tile ! Wood ! Other: _____				! Feather ! Dacron/Synthetic ! Foam Rubber ! Zip cover			
Is there a smoker in your residence? ! No ! Yes If yes, relationship: _____							
INDICATE TYPE OF ALLERGY TESTS TAKEN BEFORE		! NONE ! BLOOD ! SKIN ! OTHER: _____		INDICATE WHAT THE TESTS WERE POSITIVE TO:		! POLLENS ! MOLDS ! FOODS ! DUST ! ANIMALS ! OTHER	
HAVE YOU EVER RECEIVED CORTISONE-LIKE DRUGS (PREDNISONE, DECADRON, STEROIDS)?			! NO IF YES, DATES _____ DOSE _____ ! YES HOW LONG _____				
HAVE YOU RECEIVED ALLERGY SHOTS?		! NO ! YES IF YES, WHEN? DATES: FROM ----- TO -----					
HOW HELPFUL WERE THE SHOTS?		! MINIMAL HELP ! REACTIONS ! HELPFUL ! NO HELP		NAME AND LOCATION OF DOCTOR WHO GAVE YOU SHOTS?			