FAMILY HISTORY

Please answer the following for any illness/medical problem in your family.

Is your mother alive? Yes No State of health (or cause of death)_____

Is your father alive? Yes No State of health (or cause of death)_____

Does any member of your family have a history of the following? Please answer yes or no to the best of your knowledge. If you answer yes, please write in the family member that has the illness including parents, brothers, sisters, children, grandparents, uncles, aunts, and cousins.

ASTHMA	YES	NO	
BRONCHITIS/EMPHYSEMA	YES	NO	
HAY FEVER	YES	NO	
SINUS PROBLEMS	YES	NO	
INSECT ALLERGIES	YES	NO	
FOOD ALLERGIES	YES	NO	
ECZEMA	YES	NO	
HIVES/SWELLING	YES	NO	
FREQUENT INFECTIONS	YES	NO	
HEADACHES	YES	NO	
CYSTIC FIBROSIS	YES	NO	
CANCER	YES	NO	
HEART DISEASE	YES	NO	
BYPASS SURGERY	YES	NO	
HEART ATTACK	YES	NO	
HIGH BLOOD PRESSURE	YES	NO	
DIABETES	YES	NO	

Has any blood related relative had a heart attack or heart bypass surgery at age 50 or below? Yes, no_____

SOCIAL HISTORY

Marital status – single, married, divorced (if the patient is a child less than 18 years of age, please list the marital status of the parents)_____

If the parents are divorced, who has legal custody of the child?_____

Education- high school graduate, college graduate, graduate school_____

Other_____

Current occupation-_____ Hobbies_____

Any occupational exposures? Yes No Do they cause symptoms? Yes No

Does the patient smoke currently? Yes No (age started_____ #packs/day_____)

Would you be willing to stop smoking if you knew it contributed to your health problems? Yes No

Have you ever smoked? Yes No (If yes, at what age did you start?_____)

How many packs per day did you smoke?_____ When did you quit?_____

Any smokers in the home? Yes No (If yes, who?_____)

Any alcohol or illegal drug abuse?_____

Lisa S. Hutto, M.D._____ History taken and reviewed

Please fill out the following concerning environmental exposures causing symptoms

Are your upper or lower respiratory symptoms worsened or caused by any of the allergens listed below? Yes No
If yes please circle the allergens that cause symptoms.

House Dust	Other Animals	Tree Pollen
Feathers	Damp Basements (mold)	Barnyards/Hay (mold)
Dogs	Fallen Leaves (mold)	Pine Straw (mold)
Cats	Grass Cuttings	Ragweed/Weed Pollen

Are your upper or lower respiratory symptoms worsened or caused by any of the physical factors listed below? Yes No
If yes, please circle the physical factors that cause symptoms.

Heat	High Humidity (dampness)	High Barometric Pressure
Cold	Low Humidity (dryness)	Weather Change
Change In Temperature	Change In Humidity	Air Conditioning
Sunlight		

Are your upper or lower respiratory symptoms worsened or caused by any of the irritants listed below? Yes No
If yes please circle the irritants that cause symptoms.

Colognes or Perfumes	Cigarette Smoke
Potpourri	Laundry Detergents or Cleaning Products
Hair Sprays or Other Scented Hair Products	Automobile Exhaust

ENVIRONMENTAL HISTORY

Do you live in a home or apartment?_____
How long have you lived there? _____
List your last three residences and please remark if your symptoms have been worse or better depending on your location.

_____
_____
_____

Concerning your present residence – please circle the following:

Heating – central heat pump, central gas, radiator, other_____
Air conditioning – central, window units, no air conditioning
Crawl space or basement under house – none, damp, musty, dry
Is home on lake or pond? Yes No Age of house:_____

Bedroom (circle all that apply)

Feather Pillow	Non-Feather Pillow	Feather Comforter
Non-Feather Comforter	Dust Ruffle	Pillow Shams
Bunk Beds	Waterbed	Box Springs
Mattress	Heavy Draperies	Miniblinds
Carpeting	Hardwood Floors	Upholstered Furniture
Many Books	Stuffed Animals	Pets

List all pets who live indoors or who come inside

_____

List all outdoor pets

_____

List all pets that sleep with the patient

_____