Name:_____ Date:_____

PALMETTO ALLERGY & ASTHMA, PA

New Patient Evaluation

PAST MEDICAL HISTORY

We need to know if you have had either an allergic or adverse reaction to any drug, food or insect sting. We need to know the name of the drug, food or insect that you had a reaction to. Please list symptoms such as hives/welts, swelling, shortness of breath, wheezing, throat tightness, loss of consciousness, rash, nausea, vomiting, diarrhea. Please include the date the reaction occurred. Also include the amount of time between ingestion of the drug or food , or insect sting and the beginning of the reaction. (For example, aspirin or shrimp was taken and the reaction started 30 minutes later.) Include any treatment that was needed such as emergency room visits, doctor visits, or over the counter medicines.

Drug Allergies or Adverse Drug Reactions:

DRUG	WHAT SYMPTOMS	DATE	Time of ingestion	Time of rxn	TREATMENT
_____	CAUSED_____	_____	_____	_____	_____
_____	CAUSED_____	_____	_____	_____	_____
_____	CAUSED_____	_____	_____	_____	_____
_____	CAUSED_____	_____	_____	_____	_____

What drugs do you routinely avoid?_____

Adverse Food Reactions

FOOD	WHAT SYMPTOMS	DATE	Time of ingestion	Time of rxn	TREATMENT
_____	CAUSED_____	_____	_____	_____	_____
_____	CAUSED_____	_____	_____	_____	_____
_____	CAUSED_____	_____	_____	_____	_____

What foods do you routinely avoid?_____

INSECTS	WHAT SYMPTOMS	DATE	Time of sting	Time of rxn	TREATMENT
_____	CAUSED_____	_____	_____	_____	_____
_____	CAUSED_____	_____	_____	_____	_____
_____	CAUSED_____	_____	_____	_____	_____

Have you been stung by the same insect again? Yes, No If yes, did you have any reaction? Yes, No (describe reaction)_____

_____

Do you have an Epi-Pen or Epi-Pen, Jr? YES NO

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History taken and reviewed by clinical staff_____

REVIEW OF SYSTEMS: Please answer yes or no to the following. Please answer yes only if this is a persistent symptom. If you answer yes, please list doctor, if any, who is treating this symptom. Have you had in the LAST YEAR:

Symptom	Yes	No	M.D. Treating	Symptom	Yes	No	M.D. Treating
Daily unexplained fever				Joint pain			
Unexplained weight loss				Blurred vision			
Night sweats				Seizures			
Enlarged lymph nodes				Any hormone problems			
*Chest pain				Any psychiatric problems			
*Irregular heart rhythm				Anemia/low blood count			
*Heart murmur				Dry, scaly itchy skin			
*Heartburn				Itchy, red welts (hives)			
Chronic diarrhea				Swelling eyes, lips, feet, hands			
Chronic nausea				Severe itching (no rash)			
Prostate problems							
Frequent urination							

All Patients Please Complete

Please list all hospitalizations and surgeries.

Age	Hospitalizations and reason for	Age	Surgeries

Please complete if the patient is less than 10 years of age. Please answer yes or no.
Full term infant: yes no Premature infant: yes no Bottle fed: yes no Breast fed: yes no
Any problems at birth: yes no (if yes, please describe)_____
Any problems with formula: yes no (if yes, please describe any symptoms or change in formula)
_____
Any problems with introduction of solid foods: yes no (if yes, please describe)
_____
At what age were solid foods introduced? Cereal_____months, Fruits_____months, Vegetables_____months
Any problem with starting whole milk? yes no (if yes, describe)
_____
At what age was milk introduced into the diet?_____
Does the patient routinely avoid any food at this time? yes no If yes, what food?_____
Does the patient stay at home during the day? yes no Any other children in the home? yes no
Please list the ages of other children in the home_____
Does the patient go to daycare? yes no If yes, at what age did the patient start daycare?_____
Immunizations: Please check one _____ Yes, they are up to date _____ No they are not up to date
Has the patient had chickenpox? yes no If yes, when?_____
Has the patient had the chickenpox vaccine? yes no If yes, when?

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History taken and reviewed by clinical staff_____

All Patients Please Complete

Medical Illnesses- (problem list)- please answer yes or no to the following medical problems; if yes, please list how long you have had the problem and who treats you for this illness.

Medical Illness			How Long Present	M.D. Taking Care of Illness
High Blood Pressure	Yes	No		
Coronary Artery Disease (angina)	Yes	No		
History of Heart Attack	Yes	No		
Heart Bypass Surgery	Yes	No		
Angioplasty or Stent	Yes	No		
Congestive Heart Failure	Yes	No		
Mitral Valve Prolapse	Yes	No		
Heart Valve Problems	Yes	No		
Atrial Fibrillation	Yes	No		
Irregular Heart Rhythm	Yes	No		
High Cholesterol or Lipids	Yes	No		
Stroke or Mini Stroke (TIA)	Yes	No		
Seizures	Yes	No		
Autism	Yes	No		
Cerebral Palsy	Yes	No		
Blood Clots	Yes	No		
Sleep Apnea	Yes	No		
Emphysema	Yes	No		
Chronic Bronchitis	Yes	No		
HIV Positive	Yes	No		
Heartburn or Reflux	Yes	No		
Stomach Ulcers or GI bleeding	Yes	No		
Liver Disease (hepatitis)	Yes	No		
Ulcerative Colitis	Yes	No		
Chrohn's Disease	Yes	No		
Irritable Bowel Syndrome	Yes	No		
Anemia	Yes	No		
Low or High Platelets	Yes	No		
Diabetes	Yes	No		
Thyroid Disease	Yes	No		
Sarcoid	Yes	No		
Rheumatoid or Osteoarthritis	Yes	No		
Lupus	Yes	No		
Osteoporosis	Yes	No		
Cancer( )	Yes	No		
Depression	Yes	No		
Schizophrenia	Yes	No		
Manic-Depressive Disorder	Yes	No		
Panic or Anxiety Disorder	Yes	No		
ADD / Hyperactivity	Yes	No		
Obsessive Compulsive Disorder	Yes	No		
Psoriasis or Rosacea	Yes	No		
Eczema	Yes	No		

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History taken and reviewed by clinical staff_____

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?_____

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History taken and reviewed by clinical staff_____

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

_____

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History taken and reviewed by clinical staff_____

Current Medications

Patient:_____ Chart #_____ Date of Visit_____

Please list all current medications including drug dose and how often you take them. Please include both prescriptions and over the counter medications. Also include any eye drops or cream or ointment. Please include the approximate date that prescription medications were started, the doctor's name who prescribed them, and the reason why you are taking the medications, such as hypertension or diabetes.

Any Beta Blockers? YES NO **CAN YOU TAKE DECONGESTANTS? YES NO**

Date of last antihistamine pill/eye drop/or nasal spray taken:_____

Prescription Medications	Date Started	M.D. Prescribing	Reason for Medication

Over the Counter Medications	Reason for Medication

Drug Allergy	Drug Intolerance
1)	1)
2)	2)
3)	3)
4)	4)
5)	5)

Patient Name:_____ Date:_____ Chart#:_____

Environmental History
Indoor Air Quality Survey

New studies show that indoor air can be three to five times more polluted than outdoor air.

Please take a few moments to go through your home and answer all of these questions regarding the household and personal products you are currently using. It is important that you list the exact brand name, type, scent/fragrance, etc.

What type of laundry detergent do you use? _____
What type of liquid fabric softener do you use? _____
What type of dryer sheets do you use? _____

What cleaning products do you use:
A.) when cleaning around the kitchen? _____
B.) when cleaning dishes? _____
C.) in the bathrooms? _____
D.) in other areas of the house (bedrooms, living room, etc.)? _____

Do you use Febreze or other spray/aerosolized air fresheners around your home? YES NO

Do you have any plug-ins at home? YES NO

Any timed-release air fresheners? YES NO

Scented candles? YES NO

Reed diffusers? YES NO

Do you wear perfume or cologne? YES NO

Do you use any talcum powder or shower-to-shower powder? YES NO

Do you use any lotion? If yes, what kind? YES NO _____

When/if using, what type of sunscreen do you use? _____

When/if using, what kind of shaving cream do you use? _____

Any aftershave? If yes, what kind? YES NO _____

Do you use any hairspray, hair gels, or other similar hair care products? If yes, what kind?
YES NO _____

What kind of deodorant do you use? _____

What kind of body wash or soap do you use? _____

What kind of shampoo do you use? _____

What kind of conditioner do you use? _____

When dusting and/or vacuuming around the house, do you wear a mask? YES NO

When doing yard work, do you wear a mask? YES NO

Do you have allergenic zip covers around your: (circle all that apply) PILLOWS MATTRESS BOX SPRINGS

_____ L. S. Hutto, M.D.

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