

Patient name: _____

Today's Date: _____

Birth History – Complete for children under age 18
Birth weight _____ lb _____ oz Vaginal delivery Y/N C/Section Y/N Premature Y/N Weeks _____
Complications _____
Feeding Formula only Y/N Breast fed Y/N How long? _____
Transitioned from breast milk without problems Y/N
Problem transitioning from breast milk? _____
Are immunizations up to date? _____

Patient name: _____

Today's Date: _____

Allergy/Health Questions 2– Social and environmental history – Circle all those that apply to the patient

Family History of Allergies: None Parents Brother/Sister

Pet exposures- circle and put number if more than one

None	Dog	Cat	Bird	Rodent _____	Other _____
------	-----	-----	------	--------------	-------------

When? Past/Current How long in family? _____ yrs.

Housing

House	Apartment	Condo	Farm
-------	-----------	-------	------

How long have you lived at this residence? _____ yrs

Bedding

Pillow:	Synthetic	Feather	Unknown material	Down comforter
Mattress:	Synthetic	Feather	Unknown material	Allergen-proof covers?

Floor covering – circle as appropriate for patient

Bedroom:	Rugs	Wall-to-wall carpet	Tile	wood
Rest of House:	Rugs	Wall-to-wall carpet	Tile	wood

HVAC

Air Conditioning:	Central	Wall	None	Humidifier	
Heating:	Forced air	Radiator	Stove	Unknown	

Basement

None	Unfinished	Finished	Is there a chronic leakage? _____
------	------------	----------	-----------------------------------

Smoke Exposure

Patient smokes	Y/N	packs/day _____	for _____ years	Quit	exposed to secondhand smoke	Y/N
----------------	-----	-----------------	-----------------	------	-----------------------------	-----

Employment

Occupation: _____	Work mainly: Inside	Outside
Exposed to: Chemicals Dusty materials Building materials Irritants		
Allergens Young children no irritants/allergens Feels worse at work than home?		

Social

Alcohol use:	None	Social	Moderate	Drinks/wk? _____
Caffeine:	None	Occasional	Large	Avoids
	Coffee	Tea	Caffeinated soft drinks	

Patients Name: _____

Today's Date: _____

Allergy/Health Questions 1– Circle if patient has had any of these symptoms IN THE LAST MONTH

Constitution	Alopecia/hair loss	Endocrine	Allergy
Decrease appititie	Contact dermatitis	Cold intolerance	Drug (specify):
Chills	Eczema	Heart intolerance	Food (specify):
Failure to thrive	Hives/swelling	Other: _____	Latex
Fatigue	Rashes	ENT	Metal (Jewelry)
Fever	Itching	Bad breath/taste	Seasonal
Night sweats	Other: _____	Difficulty smelling	Surgical tape
Weight change	Eyes/Head	Ear discharge	Other: _____
Other: _____	Itchy eyes	Ear itching	Musculoskeletal
Lungs	Migraine headaches	Ear pain	Back pain
Chest tightness	Pressure/congestion	Hearing loss	Joint pain
Chronic cough	Redness of eyes	Post nasal drip	Muscle pain
Difficulty exercising	Sinus headache	Sneezing	Muscle weakness
Short of breath	Tension headaches	Snoring	Osteoporosis
sputum	Swollen eyes	Sore throat	Stiffness
Wheezing	Watery eyes	Tinnitus (ear ringing)	Other: _____
Other: _____	Other: _____	Throat clearing	Psychiatry
Hematology	Cardiovascular	Other: _____	Anxiety
Anemia	Edema/swelling	GI	Depression
Bleeding	Fainting	Abdominal pain	Developmental delay
Bruise easily	Murmurs	Constipation	Hyperactive
Swollen glands	Palptations	Diarrhea	Irritable
Other: _____	Other: _____	Heartburn (reflux)	Mood swings
Skin	GU	Nausea	Stress
Acne	Difficult urinating	Vomiting	Other: _____