

PATIENT NAME: \_\_\_\_\_  
 DATE OF BIRTH: \_\_\_\_\_  
 OCCUPATION: \_\_\_\_\_  
 CURRENT DATE: \_\_\_\_\_

ALLERGY & ASTHMA ASSOCIATES  
 JAMES R. BANKS, M.D.  
 TIMOTHY ANDREWS, M.D.  
 ROBERT S. BARRANCO, JR., P.A.-C.  
 ANNE McCONNELL, C.P.N.P.  
 277 PENINSULA FARM ROAD  
 ARNOLD, MD 21012  
 410-647-2600

- 1 Name of person filling out this form and relation to the patient: \_\_\_\_\_
- 2 Who suggested you visit us? \_\_\_\_\_
- 3 Who is your primary physician? \_\_\_\_\_
- 4 Is there any other provider who should receive a copy of our report? \_\_\_\_\_
- 5 What is the reason you were referred to us today? (asthma, hay fever, food, bee, medication allergy, etc)  
 \_\_\_\_\_  
 \_\_\_\_\_
- 6 What specific problems or symptoms are you having?(sneezing, cough, etc.) \_\_\_\_\_  
 \_\_\_\_\_

Please answer YES or NO if you have had any of the following within the past year or more:

<p><b>NOSE</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>itch Y ___ N ___</p> <p>clear drainage Y ___ N ___</p> <p>discolored mucus Y ___ N ___</p> <p>sneezing Y ___ N ___</p> <p>post-nasal drip Y ___ N ___</p> <p>nose rubbing Y ___ N ___</p> <p>nosebleeds Y ___ N ___</p> <p>polyps Y ___ N ___</p> <p>poor sense of smell or taste Y ___ N ___</p> <p>blockage Y ___ N ___</p> <p><b>SINUSES</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>fullness/pressure/pain Y ___ N ___</p> <p>recurrent sinusitis Y ___ N ___</p> <p>recurrent head colds Y ___ N ___</p> <p><b>CHEST</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>coughing Y ___ N ___</p> <p>wheezing Y ___ N ___</p> <p>tightness/pressure Y ___ N ___</p> <p>short of breath Y ___ N ___</p> <p>bronchitis Y ___ N ___</p> <p>pneumonia Y ___ N ___</p> <p>coughed up blood Y ___ N ___</p> <p>coughed up sputum Y ___ N ___</p> <p>trouble keeping up with peers when exercising Y ___ N ___</p> <p>wake up coughing/wheezing Y ___ N ___</p> <p>coughs with exercise Y ___ N ___</p> <p>ER visit for asthma attacks Y ___ N ___</p> <p>hospitalizations for asthma/pneumonia Y ___ N ___</p>	<p><b>EYES</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>tearing Y ___ N ___</p> <p>itching Y ___ N ___</p> <p>discharge Y ___ N ___</p> <p>redness Y ___ N ___</p> <p>dryness Y ___ N ___</p> <p>vision changes Y ___ N ___</p> <p>blurred vision Y ___ N ___</p> <p>glaucoma Y ___ N ___</p> <p>wear soft contacts? Y ___ N ___</p> <p><b>EARS</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>itch Y ___ N ___</p> <p>pop Y ___ N ___</p> <p>plugging Y ___ N ___</p> <p>infections Y ___ N ___</p> <p>poor hearing Y ___ N ___</p> <p>ringing Y ___ N ___</p> <p><b>Gastrointestinal</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>heartburn Y ___ N ___</p> <p>reflux Y ___ N ___</p> <p>vomiting Y ___ N ___</p> <p>diarrhea Y ___ N ___</p> <p>swallowing difficulties Y ___ N ___</p> <p>stomach pain Y ___ N ___</p> <p>food intolerance Y ___ N ___</p> <p>hepatitis Y ___ N ___</p> <p>bloating Y ___ N ___</p>	<p><b>THROAT &amp; MOUTH</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>itching Y ___ N ___</p> <p>recurrent sore throats Y ___ N ___</p> <p>hoarseness Y ___ N ___</p> <p>throat clearing Y ___ N ___</p> <p>bad breath Y ___ N ___</p> <p>canker sores Y ___ N ___</p> <p><b>SKIN</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>rash Y ___ N ___</p> <p>hives/welts Y ___ N ___</p> <p>swelling Y ___ N ___</p> <p>itching Y ___ N ___</p> <p>eczema Y ___ N ___</p> <p>dryness Y ___ N ___</p> <p><b>CONSTITUTIONAL</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>headaches Y ___ N ___</p> <p>irritability Y ___ N ___</p> <p>aggressive behavior Y ___ N ___</p> <p>poor sleeping Y ___ N ___</p> <p>fatigue Y ___ N ___</p> <p>snoring Y ___ N ___</p> <p>cold/heat intolerance Y ___ N ___</p> <p>dizziness Y ___ N ___</p> <p>fever Y ___ N ___</p> <p>weight changes Y ___ N ___</p> <p>night sweats Y ___ N ___</p> <p>growth delay Y ___ N ___</p> <p>altered school/work performance Y ___ N ___</p> <p>loss of balance Y ___ N ___</p> <p>dizziness on change of positions Y ___ N ___</p>
---	---	---

Which of the above are of greatest concern to you and impact most on your quality of life? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

7 Please provide us with some details of the history of your problem.  
When did it begin? Was it preceded by some other type of allergic condition? Has there been a trend or variation of symptoms or severity over the years? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8 Have you noticed a pattern with your symptoms? Is it worse in certain locations, months or seasons?  
\_\_\_\_\_  
\_\_\_\_\_

Are your symptoms affected by:

dust	Y	___	N	___	cut grass	Y	___	N	___	stress	Y	___	N	___
cats	Y	___	N	___	mold/mildew	Y	___	N	___	spring	Y	___	N	___
dogs	Y	___	N	___	wind	Y	___	N	___	summer	Y	___	N	___
other animals	Y	___	N	___	weather changes	Y	___	N	___	fall	Y	___	N	___
leaf raking	Y	___	N	___	fumes/chemical odors	Y	___	N	___	winter	Y	___	N	___
feathers	Y	___	N	___	poor air quality	Y	___	N	___	respiratory infections	Y	___	N	___
soaps/detergents	Y	___	N	___	viruses	Y	___	N	___					
exercise	Y	___	N	___	laughter	Y	___	N	___					
heat/cold	Y	___	N	___	newsprint	Y	___	N	___					

(See Question #15 for foods, bee stings, latex)

9 What has provided the most relief (avoidance, specific medicines, allergy shots...)?  
\_\_\_\_\_  
\_\_\_\_\_

10 What hasn't helped? \_\_\_\_\_  
\_\_\_\_\_

11 If you have undergone prior allergy evaluation, please list physician, approximate date, and any known details regarding test results and treatment. \_\_\_\_\_  
\_\_\_\_\_

Have you had a chest x-ray or sinus CAT scan within the past 3 years? Y \_\_\_ N \_\_\_ If so, where? \_\_\_\_\_

12 Describe your smoking history:

never	_____	Average number of packs/day over the years	_____
former	Y ___ N ___	Numbers of years you have smoked	_____
current	Y ___ N ___	If applicable, how many years ago did you stop?	_____

13 Please list all current medications, both prescription and over the counter. Also list all herbal and/or nutritional products: When were meds started?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

14 Please list all known medication allergies and intolerances. Describe the nature of reaction or side effect for each drug and approximate date or age at which the problem surfaced. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

15 Please list all known or suspected allergies or intolerances to foods, food additives and colorants, stinging insect venom, and latex (natural rubber) products. Describe the nature of the reaction and approximate date or age at which the problem surfaced.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

16 Have you had contact allergies to poison ivy, adhesives, metals, cosmetics, etc.? Describe:

\_\_\_\_\_  
\_\_\_\_\_

17 If not yet covered above, have you had any of the following:

asthma	Y ___ N ___	recurrent sinusitis	Y ___ N ___	sinus surgery	Y ___ N ___
nasal allergies	Y ___ N ___	recurrent ear infections	Y ___ N ___	pneumonia	Y ___ N ___
eczema	Y ___ N ___	PE ear tubes	Y ___ N ___	recurrent bronchitis	Y ___ N ___
recurrent hives	Y ___ N ___	adenoidectomy	Y ___ N ___	meningitis	Y ___ N ___
recurrent swelling	Y ___ N ___	tonsillectomy	Y ___ N ___	abscesses	Y ___ N ___

18 Please describe your routine for regular exercise: \_\_\_\_\_

\_\_\_\_\_

Do you exercise regularly outdoors within 500 yards of a major roadway? Y \_\_\_ N \_\_\_

19 **Home Environment:** Age of home \_\_\_\_\_ rent \_\_\_\_\_ own \_\_\_\_\_

Number of indoor cats? \_\_\_\_\_ For how long? \_\_\_\_\_  
Number of indoor dogs? \_\_\_\_\_ For how long? \_\_\_\_\_  
Other furred pets in home? \_\_\_\_\_ For how long? \_\_\_\_\_  
If cats or dogs were present only in past, how long has it been since such pets were in the home?  
\_\_\_\_\_ What type of animal? \_\_\_\_\_

Number of occupants who ever smoke in the home? \_\_\_\_\_

Relationship of smoker(s) to patient? \_\_\_\_\_

Central AC? Y \_\_\_ N \_\_\_

If you have central AC do you routinely open windows seasonally, temperature permitting? Y \_\_\_ N \_\_\_

Your bedroom:

wall to wall carpet Y \_\_\_ N \_\_\_ hardwood or tile Y \_\_\_ N \_\_\_ area rugs Y \_\_\_ N \_\_\_

washable throw rugs Y \_\_\_ N \_\_\_ (not washable)

Are pillows covered in special allergen-proofed encasings? Y \_\_\_ N \_\_\_

Is top mattress similarly encased? Y \_\_\_ N \_\_\_ (N/A if waterbed)

is box spring encased? Y \_\_\_ N \_\_\_ Is comforter encased? Y \_\_\_ N \_\_\_

Is patient in a daycare setting? Y \_\_\_ N \_\_\_ If so, how many other children in attendance? \_\_\_\_\_

Pets at daycare? \_\_\_\_\_ Smokers? Y \_\_\_ N \_\_\_

Other exposure to pets outside the home? (Friends, neighbors, relatives) \_\_\_\_\_

If you live much of the year in a college dorm or apartment, please comment on that setting with the above issues in mind: \_\_\_\_\_

Are there any particular concerns regarding either the home or work setting not addressed above? (e.g., mouse or cockroach infestations, water damage, mold growth, leaky roof, poor ventilation, etc.)

Please elaborate: \_\_\_\_\_

\_\_\_\_\_

PATIENT NAME: \_\_\_\_\_

20 Review of Systems (Have you had any of the following within the past year?)

<b>Heart</b>			<b>Musculoskeletal</b>			<b>Neuropsychiatric</b>		
<i>no problems</i>	Y	___ N ___	<i>no problems</i>	Y	___ N ___	<i>no problems</i>	Y	___ N ___
high blood pressure	Y	___ N ___	arthritis	Y	___ N ___	migraine	Y	___ N ___
irregular beats	Y	___ N ___	fibromyalgia	Y	___ N ___	seizures	Y	___ N ___
murmur	Y	___ N ___	osteoporosis	Y	___ N ___	unconscious spells	Y	___ N ___
heart attack	Y	___ N ___	backaches	Y	___ N ___	tingling/weakness		
surgery	Y	___ N ___	muscle spasms	Y	___ N ___	in hands/feet	Y	___ N ___
ankle swelling	Y	___ N ___	joint redness	Y	___ N ___	trembling of extremity	Y	___ N ___
angina/chest pain	Y	___ N ___	joint swelling	Y	___ N ___	difficulty concentrating	Y	___ N ___
<u>shortness of breath:</u>			joint heat	Y	___ N ___	impulsive behavior	Y	___ N ___
when walking	Y	___ N ___				chronic anxiety	Y	___ N ___
when lying down	Y	___ N ___				memory difficulty	Y	___ N ___
when climbing			<b>Blood/Lymphatic</b>			stress	Y	___ N ___
1 flight of stairs	Y	___ N ___	<i>no problems</i>	Y	___ N ___	depression	Y	___ N ___
on walking			anemia	Y	___ N ___	irritability	Y	___ N ___
several blocks	Y	___ N ___	easy bruising	Y	___ N ___	mood swings	Y	___ N ___
			easy bleeding	Y	___ N ___	difficulty interacting	Y	___ N ___
<b>Endocrine</b>			swollen glands	Y	___ N ___	drug/alcohol problems	Y	___ N ___
<i>no problems</i>	Y	___ N ___	blood clots	Y	___ N ___			
diabetes	Y	___ N ___	tired without reason	Y	___ N ___			
thyroid problems	Y	___ N ___				<b>Lungs</b>		
brittle nails	Y	___ N ___	<b>Genitourinary</b>			pneumonia	Y	___ N ___
change in hair texture	Y	___ N ___	<i>no problems</i>	Y	___ N ___	pleurisy	Y	___ N ___
change in skin texture	Y	___ N ___	bedwetting	Y	___ N ___	collapsed lung	Y	___ N ___
premature puberty	Y	___ N ___	frequent urination	Y	___ N ___	bronchitis	Y	___ N ___
delayed puberty	Y	___ N ___	difficult urination	Y	___ N ___	last TB test		
			yeast infection			Pos_____ Neg _____		
			on antibiotics	Y	___ N ___			
			accidental urination			<b>Liver</b>		
			with cough	Y	___ N ___	hepatitis	Y	___ N ___
						cirrhosis	Y	___ N ___

Other symptoms not listed above? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

21 Past Medical History - Have you had any of the following at any time in the past?:

Tuberculosis	Y	___ N ___	Hiatal Hernia	Y	___ N ___	epilepsy/seizures	Y	___ N ___
Positive TB test	Y	___ N ___	Ulcers	Y	___ N ___	congenital defects	Y	___ N ___
Migraine	Y	___ N ___	Irritable Bowel	Y	___ N ___	congenital heart		
Diabetes	Y	___ N ___	Crohn's Disease	Y	___ N ___	disease	Y	___ N ___
Cataracts	Y	___ N ___	lactose intolerance	Y	___ N ___	heart attack	Y	___ N ___
Glaucoma	Y	___ N ___	hepatitis	Y	___ N ___	angioplasty	Y	___ N ___
GERD	Y	___ N ___	arthritis	Y	___ N ___	bypass surgery	Y	___ N ___
stroke	Y	___ N ___	cancer	Y	___ N ___	abnormal stress test	Y	___ N ___
abnormal bone density	Y	___ N ___	osteoporosis	Y	___ N ___	drug addiction	Y	___ N ___
thyroid disease	Y	___ N ___	ADD/ADHD	Y	___ N ___	alcoholism	Y	___ N ___

(Graves, Hashimoto's, thyroiditis, tumor, hyperthyroidism, hypothyroidism)

