CAARD
CENTER FOR ASTHMA, ALLERGY AND RESPIRATORY DISEASE, PLLC

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PATIENT NAME: _____ DOB: _____

Requesting physician: _____

What are the problems that bring you to this practice? _____

_____

_____

_____

CURRENT SYMPTOMS: **Do you have?** (Circle all appropriate answers.)

Eye symptoms: none, itching, watering, redness, swelling, crusting, dryness, burning, dark circles, blurred vision, other _____

Ear symptoms: none, itching, popping, congested, frequent infections, fluid in middle ear, blocked, hearing loss, earache, dizziness, other _____

Nasal symptoms: none, sneezing, itching, sniffles, watery discharge, cloudy discharge, congestion, nosebleeds, loss of sense of smell/taste, polyps, frequent sinus infections, nasal dryness, snoring at night, other _____

Mouth and throat symptoms: none, sore throat, hoarseness, itchy throat, difficulty swallowing, swollen neck glands, mouth breathing, frequent strep throat, frequent tonsillitis, postnasal drip, bad breath/foul taste, other _____

Sleep history and symptoms: none, weight gain within last 12 months_____ lb, snoring, grunting, witnessed stop breathing, restless night sleep, daytime sleepiness, poor memory and concentration, could fall asleep while driving, other _____

Headaches: none, infrequent, occasional, frequent, occur with sinus symptoms, sharp, dull, pounding, facial, forehead, temples, back of head, migraine, other _____

Chest symptoms: none, chronic cough, chest tightness/congestion, wheezing, shortness of breath at rest/on exertion, wheeze/cough after exercise, sputum production, chest pain or pressure, heart murmur, sudden onset of difficulty breathing, coughed up blood, swollen legs, blue lips or fingernails, leg cramps when you walk, other _____

Stomach/intestinal symptoms: none, nausea and vomiting, bloating, loss of appetite, abdominal pain or cramping, diarrhea frequently, constipation frequently, pain or difficulty swallowing, heartburn or indigestion, queasy stomach, acid/bitter taste, cough upon lying down, other _____

Skin symptoms: none, dry skin, hives, swelling, itchy skin, eczema, poison ivy/oak allergy, skin sensitivity to metals, chemicals, cosmetics, other _____

Insect sting reaction: none, large swelling, hives, difficulty breathing, throat swelling, dizzy, other _____ Stung by: bee, fire ant, yellow jacket, wasp, hornet, other _____

Which of the following do you think cause or make your symptoms worse? (Please check appropriate boxes.)

Trigger	Nose/Sinus Eyes/Ears Symptoms	Asthma/ Shortness of Breath Symptoms	Hives/ Eczema Symptoms	Stomach/ Intestinal Symptoms	Other
Parks/fields					
Mowed grass					
Gardening					
House dust					
Weather changes					
Windy days					
Humid days					
Hot days					
Cold days					
Air conditioning					
Forced air/heat					
Drafts					
Tobacco smoke					
Fumes/aerosols/sprays					
Cosmetics/perfumes					
Chemicals					
Soap powder					
Newspaper print					
Pets/animal exposure (list)					
Exercise					
Tension/excitement					
Clothing/fabrics					
Medicines (which)					
Milk/dairy products					
Beer/wines					
Certain foods (list)					
Menstrual periods					
URIs					
Other(s)					

Comments/explanation: _____

_____

_____

_____

Insect stings:

	Yes	No
Do you have problems with insect stings?	( )	( )
Local swelling	( )	( )
Tongue or lip swelling	( )	( )
Scattered hives	( )	( )
Shortness of breath	( )	( )

Have you ever been treated in an emergency room for an insect sting? If so, describe: _____

_____

Food allergies/sensitivities: Do you have problems with any food ingestants? If yes, describe problem. For instance: swelling or itching of tongue, lips, or mouth? Rashes or hives? Immediate or delayed vomiting or diarrhea?

Eggs		Fish	
Wheat		Melon	
Milk		Fruit	
Cheese		Walnuts	
Crab		Peanuts	
Lobster		Tomatoes	
Shrimp		Other	

Drug allergies/sensitivities: Please list all medications that you have had an adverse reaction to and a description of that reaction.

Medication Name	Type of Reaction

Immunizations:

	Yes	No	DATE
Childhood	( )	( )	
Hepatitis	( )	( )	
Tetanus	( )	( )	
Pneumovax	( )	( )	
Chicken pox vaccine	( )	( )	

PAST ILLNESSES: (Please check all illnesses you have had.)

_____ Rh fever	_____ Valvular heart disease	_____ Uterine cancer
_____ Scarlet fever	_____ Congestive heart failure	_____ Cervical cancer
_____ Lyme disease	_____ Angina/coronary artery	_____ Anemia
_____ Migraine HA	disease/myocardial infarction	_____ Hemophilia
_____ Hypertension	_____ Atherosclerotic peripheral	_____ HIV
_____ Diabetes mellitus Type 1 or 2	vascular disease	_____ Benign prostatic hypertrophy
_____ Hyperlipidemia	_____ Hiatal hernia/ gastroesophageal	_____ Prostate cancer
_____ Glaucoma	reflux disease	_____ Eczema
_____ Cataracts	_____ Peptic ulcer disease	_____ Atopic dermatitis
_____ Macular degeneration	_____ Ulcerative colitis	_____ Seborrhea
_____ Thyroid	_____ Crohn's disease	_____ Psoriasis
_____ Arthritis	_____ Lactose intolerant	_____ Hives
_____ Gout	_____ Irritable bowel syndrome	_____ Cradle cap
_____ Bursitis	_____ Colon cancer	_____ Skin cancer
_____ Fibromyalgia	_____ Colon polyps	_____ Seizure
_____ Raynaud's	_____ Diverticulosis/diverticulitis	_____ Stroke
_____ Lupus (SLE)	_____ Pancreatitis	_____ Carpal tunnel
_____ Breast cysts	_____ Hepatitis	_____ Nerve damage
_____ Breast cancer	_____ Gallbladder disease	_____ Mental illness
_____ Pneumonia	_____ Mononucleosis	_____ Depression
_____ Pleurisy	_____ Nephritis	_____ Anxiety/neurosis
_____ Pneumovax (date given) _____	_____ Urinary tract infection	_____ Multiple sclerosis
_____ Seasonal allergies	_____ Kidney stones	_____ Muscular dystrophy
_____ Nasal polyps	_____ Polycystic ovaries	_____ Meningitis
_____ Asthma	_____ Ovarian cancer	_____ Encephalitis

Past Illnesses continued:

_____ Exercise-induced asthma
_____ Chronic bronchitis
_____ Emphysema/COPD
_____ Asbestosis
_____ Tuberculosis or positive skin test
_____ Arrhythmia/palpitations
_____ Murmur

_____ Pelvic inflammatory disease/ sexually transmitted disease
_____ Endometriosis
_____ Uterine fibroids
_____ Osteoporosis/osteopenia

_____ Obstructive sleep apnea
_____ Attention deficit disorder or attention deficit/hyperactivity disorder
_____ Other _____

Hospitalizations: Please list. _____

_____

Surgeries: Please list. _____

_____

Injuries: Please list. _____

_____

Medications: Please list all medications that you are currently taking, dosage, frequency, and for what condition.

MEDICATION NAME/DOSAGE	FREQUENCY	FOR WHAT CONDITION

FAMILY HISTORY:

Mother's (M) age ____ Alive/Deceased _____ Number of Brothers (B) ____ Alive ____ Deceased
Father's (F) age ____ Alive/Deceased _____ Number of Sisters (S) ____ Alive ____ Deceased
Number of children: ____ Ages of daughters: _____ Ages of sons: _____
Comments: _____

Does anyone in your immediate family have?

	YES	NO	Family member (M)	(F)	(B)	(S)	(C)		YES	NO	Family member (M)	(F)	(B)	(S)	(C)
Allergies	( )	( )	( )	( )	( )	( )	( )	Arrhythmia/palpitations	( )	( )	( )	( )	( )	( )	( )
Food allergies	( )	( )	( )	( )	( )	( )	( )	Diabetes	( )	( )	( )	( )	( )	( )	( )
Stinging insect allergy	( )	( )	( )	( )	( )	( )	( )	Thyroid disease	( )	( )	( )	( )	( )	( )	( )
Asthma	( )	( )	( )	( )	( )	( )	( )	Arthritis	( )	( )	( )	( )	( )	( )	( )
Emphysema/COPD	( )	( )	( )	( )	( )	( )	( )	Liver disease	( )	( )	( )	( )	( )	( )	( )
Cystic fibrosis	( )	( )	( )	( )	( )	( )	( )	Cancer	( )	( )	( )	( )	( )	( )	( )
Lung cancer	( )	( )	( )	( )	( )	( )	( )	Hives	( )	( )	( )	( )	( )	( )	( )
Sarcoidosis	( )	( )	( )	( )	( )	( )	( )	Eczema	( )	( )	( )	( )	( )	( )	( )
Tuberculosis	( )	( )	( )	( )	( )	( )	( )	Heart disease	( )	( )	( )	( )	( )	( )	( )
Tobacco dependence	( )	( )	( )	( )	( )	( )	( )	Obesity	( )	( )	( )	( )	( )	( )	( )
Strokes	( )	( )	( )	( )	( )	( )	( )	Obstructive sleep apnea	( )	( )	( )	( )	( )	( )	( )
High blood pressure	( )	( )	( )	( )	( )	( )	( )	Other _____	( )	( )	( )	( )	( )	( )	( )

SOCIAL HISTORY:

( ) Single ( ) Married ( ) Divorced ( ) Widowed ( ) In a relationship

Occupation of patient _____ Occupation of spouse: _____

Occupation of mother: _____ Occupation of father: _____

Does patient drink alcoholic beverages? ( ) Yes ( ) No Type and frequency: _____

Cigarette use: Yes/No Age began: _____ Age quit: _____ Peak amount: _____ Average: _____

If you still smoke, do you want to stop? ( ) Yes ( ) No

Does anyone in the home smoke? ( ) Yes ( ) No
( ) pipe ( ) cigarette ( ) cigar How much? _____

Caffeine consumption? ( ) Yes ( ) No Coffee/tea/soda? How much? _____

What is your primary language? _____

Any travel outside New England within 1 year? _____

Financial problems? ( ) Major ( ) Average ( ) Minor
Nervous tension? ( ) Major ( ) Average ( ) Minor
Work adjustment? ( ) Major ( ) Average ( ) Minor

	Yes	No	
Do you feel safe in your home?	( )	( )	
Do you have a working smoke detector?	( )	( )	
Do you have a working carbon monoxide detector?	( )	( )	
Are there firearms in the home?	( )	( )	Are they locked? ( ) Yes ( ) No
Do you have an advanced directive?	( )	( )	

Advanced directive is a legal document stating preferences for medical care if you are no longer able to make decisions due to illness or incapacity.

Hobbies: _____

Exercise: _____

Environment:

How long have you lived in New England? _____
Prior state(s)? _____

Location of home	( ) Country	( ) Suburb	( ) City		
Type of home	( ) Apartment	( ) Frame	( ) Brick		
	( ) Bungalow/2 story	( ) Condo	( ) Mobile home		
Heating system	( ) Forced air	( ) Steam	( ) Forced hot water	( ) Electric	
	( ) Air conditioning	( ) Air purifier	( ) Woodstove/fireplace		

How old is dwelling: _____ How long lived there? _____

Basement	( ) Yes	( ) No	What is basement used for? _____
Is basement	( ) Dry	( ) Damp	( ) Finished
Dehumidifier	( ) Yes	( ) No	
Humidifier	( ) Yes	( ) No	

Animals:

Do you have any pets? List. _____
How long have these pets been with you? _____
Does the animal have full range of the house? _____
Does the animal sleep on the patient's bed? _____
Does animal exposure make symptoms worse? _____

Patient's bedroom:

Floor Covering		Walls		Window Coverings	
Carpeting w/pad	( )	Wallpaper	( )	Washable curtains	( )
Carpeting w/o pad	( )	Pictures	( )	Non-washable curtains	( )
Rug w/pad	( )	Pennants	( )	Blinds	( )
Rug w/o pad	( )	Tapestries	( )	Other _____	( )
Throw rug	( )	Other _____	( )		
Linoleum	( )				
Hardwood	( )				
Other _____	( )				

Closet		Pillow		Mattress	
None	( )	Age _____ years		Age _____ years	
Door kept open	( )	Type:		Type:	
Door kept closed	( )	Feather	( )	Innerspring cotton	( )
Used for storage	( )	Foam rubber	( )	Foam rubber	( )
Seasonal clothes	( )	Synthetic	( )	Other _____	( )
		Hypoallergenic cover	( )	Hypoallergenic cover	( )

Any houseplants in bedroom? _____ Upholstered furniture? _____

What is bedding made of? (Down comforters, wool blankets, quilts, etc.) _____

Travel:
Do you feel better when traveling outside of New England? ( ) Yes ( ) No

REVIEW OF SYMPTOMS AND SYSTEMS: (Please circle all symptoms you have.)

Lack of energy, daytime sleepiness, trouble sleeping, snoring, loss of appetite, weight changes, fevers, fatigue, chills, night sweats.

Eye problems, such as double or blurred vision, loss of vision, glaucoma, cataracts, wears contact lenses, glasses, dentures.

Hearing problems, buzzing/ringing in ears, hearing aids.

Sinus problems, broken nose.

High blood pressure, heart disease, palpitations.

Stomach problems, change in bowel habits, choking on food.

Bloody or tarry stools, jaundice, liver problems, ulcers, gallstones, diverticulitis.

Urinary problems: Frequency, infections, stones, bladder.
Men: Prostate problems, nighttime urination.
Women: Abnormal menstrual periods, pregnant.

If you are a woman are you past/peri- menopause? Yes At what age? ____ No

Do you take estrogen replacement/birth control pills? Yes, no.

Joint pain, swelling or redness, arthritis, back pain.

Review of Symptoms and Systems continued:

Muscle aches or tenderness, gout.

Rash, itching or other skin problems.

Paralysis (even temporary), stroke, numbness, loss of balance, history of falls.

Seizures, loss of memory, headaches, loss of consciousness.

Unusual thoughts, nervousness, crying or sadness, depression.

Thyroid disorder, diabetes, excess thirst, hunger or urination.

Bleeding, easy bruising, risk factors for HIV, anemia, cancer.