ALLERGY & ASTHMA HISTORY

Name _____

Date of Birth _____ Age: _____

Today's Date _____

Allergy, Asthm
Pulmonary
Associates, PA

M.S. Yassin, M.D.

Patient: Please fill out this side: | **Physician Notes:**

Primary physician: _____

Referring physician: _____

The main problems for coming here are:

	YES	NO	
Nasal congestion or runny nose	☐	☐	_____
Itchy or watery eyes	☐	☐	_____
Sneezing	☐	☐	_____
Snoring or breathing through the mouth	☐	☐	_____
Drainage down the throat	☐	☐	_____
Frequent yellow or green nasal drainage	☐	☐	_____
Coughing	☐	☐	_____
Wheezing or shortness of breath	☐	☐	_____
Diagnosis of asthma made ____ years ago			_____
Number of past hospitalizations for asthma: _____			_____
Number of past emergency visits for asthma: _____			_____
Days of school or work missed in past year: _____			_____
Possible reaction to [food or drug]: _____			_____
Age of onset of symptoms: _____			_____
Bee sting reactions	☐	☐	_____
Rashes	☐	☐	_____
Frequent infections	☐	☐	_____
Number of ear infections in the past year: _____			_____
Number of sinus infections in the past year: _____			_____
Number of pneumonias during lifetime: _____			_____
Headaches	☐	☐	_____
Vomiting, diarrhea, or abdominal pain	☐	☐	_____
Transfer of allergy care from Dr. _____			_____
Continuation of allergy shots started ____ years ago			_____
Other (explain):			_____

These symptoms occur:

Spring ☐ Summer ☐ Fall ☐ Winter ☐

Days or weeks at a time ☐ All the time ☐ _____

At home ☐ Room: _____ _____

Worse outdoors ☐ At work or school ☐ _____

☐ Worse at night or morning _____

Best time of year: _____ _____