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PEDIATRIC& ADULT ALLERGY/IMMUNOLOGY
PEDIATRIC PULMONARY DISEASE
SLEEP DISORDERS MEDICINE

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THE AMERICAN COLLEGE OF CHEST PHYSICIANS
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Updated 01/26/2015

Date of Consult_____

ALLERGY IMMUNOLOGY PULMONARY HISTORY

PLEASE PRINT CLEARLY, ANSWERING CAREFULLY AND COMPLETELY.

PATIENT NAME_____ Birth Date_____
Address_____ City_____ Zip Code_____
Home Phone_____ Cell Phone _____
Physician _____ Place of employment_____
Type of Work _____ Work phone _____
Spouse (if applicable) _____ Referred by _____
Emergency contact name _____ Contact phone number_____

For Pediatric Patients:

Parent's names _____Phone number_____
Father's occupation_____ Address if different from child _____
Mother's occupation _____ Address if different from child_____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS CAREFULLY AS BEST YOU CAN. SOME MAY NOT APPLY TO YOU. SOME YOU MAY WANT TO DISCUSS WITH DR. BRAY IN PRIVATE.

PLEASE FILL IN BLANKS AND/OR CIRCLE YOUR ANSWER

CHIEF COMPLAINT What is your main problem?_____
_____
_____
_____

HISTORY OF PRESENT ILLNESS , **TELL ME MORE ABOUT YOUR MAIN PROBLEM**
_____
_____
_____
_____
_____

How long have you had your problem? _____

PLEASE FILL IN BLANKS AND/OR CIRCLE YOUR ANSWER

Are symptoms: Progressing Regressing

How many physicians have you seen about your health problems in the last 5 years? Please list them and what they told you.
_____
_____
_____

SYMPTOMS

EYES: Itch Burn Water Swell Infection Discharge Circles under your eyes

EARS: Itch Fullness Popping Frequent infections

NOSE: Sneezing Running Plugging Itch Mouth breathing Sinus pressure

When? _____

THROAT: Soreness Postnasal drip Roof of mouth itches Mucus in the A.M.

CHEST: Cough Pain Wheezing Sputum: Shortness of Breath
What color _____ At Rest
Amount _____ On Exertion
Any blood **YES** **NO**

Is there any history of choking or aspiration of foreign material (such as vomit, a peanut, coin, or plastic toy) going down the windpipe? ____ If so, please explain_____
_____
_____

SKIN:

Inflammation Eczema Hives Dry skin Atopic dermatitis Swelling Other _____

Times of year symptoms are worse:

Year round Seasonal Which season or seasons_____
Seasonally exacerbated Which Seasons are worse_____ Which Season is best _____
Monthly variations (menses, workdays vs. days off) _____
Is problem usually worse at night? _____ Are symptoms better indoors or outdoors?
Effect of vacation or major geographic change? _____
What effects do weather changes have? _____
Does vigorous exercise then cooling off make you cough or wheeze? **YES NO** If yes Explain_____

TRIGGERS: List anything that you feel makes your condition worse _____
Do symptoms occur around: **Circle all that apply**

Old leaves Hay Lakeside Barns Summer homes Damp basement Dry attic Lawn mowing Animals
Perfume Dust Plants Weeds Grass Rain Smoke Cold air Newspaper Fabrics Dust storms
Cosmetics Strong smells Candle shops Others (list) _____

Have you ever had a serious reaction to an insect sting or bite? **YES NO** What was it? _____ What year? _____

PAST MEDICAL HISTORY

Have you ever had any major illnesses or surgery? _____ If so, what and when? _____

_____

_____

_____

Have you been in the hospital with any allergy or breathing problems? **YES NO** How many times? ___ Last admission_____
Have you been to the E.R. with any allergy or breathing problems? **YES NO** How many times? _____ Date of last visit _____
Do you have any other chronic health problems? **YES NO** What? _____
Have you ever had Asthma? **YES NO** Repeated bronchitis **YES NO** Pneumonia **YES NO**

FAMILY HISTORY – WHAT TYPE OF ALLERGY AND OTHER HEALTH PROBLEMS HAVE YOUR FAMILY MEMBERS HAD?

Allergies and other Health problems:

Blood Mother _____
Blood Father _____
Blood Siblings _____
_____
Children _____
_____
Close blood relatives' _____
_____

Is there a family history of: **Who?**

Cystic Fibrosis _____
Immune deficiencies _____
Severe headaches _____
Pulmonary diseases _____
Other diseases _____
_____
_____
_____

DEVELOPMENTAL HISTORY

During the time your mother was pregnant with you, (or you were pregnant with the patient) were there any problems **YES NO**
If so, what kind of problem _____
Smoking? **YES NO** _____
Drank alcohol or took drugs? **YES NO** Which one?_____

Any medication? **YES NO** If yes, what is it and what is it for? _____
Any problems at the time of delivery **YES NO** Explain_____ Birth weight _____
Age of the infant at the time of delivery in weeks? _____
Any problems shortly after birth? **YES NO** Explain_____
Problems as an infant? **YES NO** Explain_____
Problems with colic? **YES NO** Explain_____
Problems with food allergies? **YES NO** Explain_____
Any eczema? **YES NO** Explain_____
Please indicate at which age in months the child first:

(1) Smiled _____
(2) Begin to walk _____
(3) Spoke first words _____

How are the child's school grades? _____
Any significant school related problems? **YES NO** What? _____
Does the child get along with his peers? **YES NO** Explain: _____

PHYSIOLOGICAL/SOCIAL HISTORY

Where does your child stay during the day? Home Grandmother Daycare Other
Any recent divorce or family disruption? **YES NO** _____
New marriage? **YES NO** _____
Is anyone in your family seriously ill? **YES NO** _____
Any recent death in the family? **YES NO** If so, Who?_____ When?_____
Are there any drug or alcohol problems in the family **YES NO** Who? _____
Is there any significant recurrent conflict between the father & Mother (husband & wife) **YES NO**
Do you have a spiritual belief system? **YES NO**
Do you actively participate in it? **YES NO**
Do you pray or meditate? **YES NO**
Are you under a lot of stress? **YES NO** If so explain: _____
Have you ever had a nervous breakdown? **YES NO** _____
Do you suffer from or have you been treated for PTSD? **YES NO** _____
Do you have or have you had any major recent financial problems? **YES NO** _____
Are things at home okay? **YES NO** _____
Do you get along well with your mate/siblings? **YES NO** _____
Do you enjoy your family? **YES NO** _____
Do you enjoy your life? **YES NO** _____
Do you suffer from depression? **YES NO** _____
Have you ever seriously considered killing yourself? **YES NO** _____
Have you taken any intravenous drugs outside of legitimate medical supervision? **YES NO** _____
Have you had contact with anyone with tuberculosis? **YES NO** _____
Do believe that you may have been exposed to AIDS or have AIDS? **YES NO** _____
Do you have or have you had Hepatitis B or C? **YES NO** _____
Are you: Heterosexual Homosexual Bisexual Not Sexual

ENVIRONMENTAL HISTORY

Where were you born? _____
How long have you lived in West Texas? _____
What type of work do you currently do? _____
Have you been repeatedly exposed to potent chemicals or industrial dust? **YES NO**
Please provide your work history with the most recent first:

EMPLOYER INDUSTRY TYPE JOB TASKS START/STOP EXPOSURES

_____
_____
_____

Were you or are you in the military? **YES NO** If so, what branch? _____
What did you do? _____. How long were you in the military? _____
Were you exposed to any significant chemicals? **YES NO** If so, what chemicals? _____
Were you directly involved in combat? **YES NO** When_____ Where_____ How Much _____
Do you have any hobbies that involve chemicals or dust? **YES NO** If so, what? _____
Does anyone smoke in the house? **YES NO** Who? _____
Do you live near a factory, plant, oil well, gas well or cotton gin? **YES NO** _____
Do you live on a farm? **YES NO** _____

HOME

Do you live in the: City Rural
Type of house _____ Age of house _____
Do you live in an: Apartment Rent house Age of the apartment/house _____
Has your home ever been flooded **YES** **NO** When?_____
Type of air conditioning Central Window Evaporative
Type of heating Central Wood stove Open gas Fire place
Do you have pets? **YES** **NO** Dogs Cats Other _____
Type of cook stove Electric Gas
Do you ever see any roaches **YES** **NO** _____
Do you ever seen any mice **YES** **NO** _____

BEDROOM TYPE AGE
Pillow _____
Mattress _____
Blankets (type) _____
Perfumed candles _____
Stuffed toys _____
Books _____
Humidifier _____
Carpet _____

LIVING ROOM TYPE AGE
Furniture (stuffed) _____
House plants _____
Artificial plants _____
Rug, carpet, tile wood _____
Potpourri _____
Carpet deodorizers _____
Air fresheners _____

BATHROOM

Mold or Mildew **YES** **NO**
Carpet **YES** **NO**

Is there any place in the home where the symptoms are worse? _____

ALLERGIES TO FOODS

Do any foods seem to cause a rash, hives, eczema, swelling, make your mouth itch, nose run, give you headaches, make your stomach cramp, give you diarrhea, make you cough, or wheeze? **YES** **NO**

List any foods that seem to cause problems and the symptoms which you feel they cause _____
_____

Do any of these cause problems? PLEASE CIRCLE ALL THAT APPLY

Cheese Mushrooms Beer Melons Bananas Fish Nuts Citrus Fruits Peanuts Eggs
Shellfish Milk Soy Wheat Other _____
Do you have frequent diarrhea? **YES** **NO** _____
Is there any mucus in your stool? **YES** **NO**_____
Do you have blood in your stools? **YES** **NO**_____
Have you ever had an asthma attack or bad reaction shortly after eating a food? **YES** **NO** What food? _____
What happens and how soon after you eat it? _____

REFLUX

Do you wake with a sour, acid taste or a metallic taste? **YES** **NO** _____
Do antacids help your problem and relieve any chest discomfort you have? **YES** **NO** _____
Do you have a hiatal hernia? **YES** **NO** _____
Do you have a lot of heartburn? **YES** **NO**_____
Do you vomit or spit up easy? **YES** **NO** _____
Does food tend to hang up in your throat when you swallow? **YES** **NO**_____

IMMUNIZATIONS

Are you and/or your child's immunizations up to date? **YES** **NO**
If not what are you/your child behind on? _____
Have you had any of the following? Please circle what applies. **Pneumonia shot** **Pneumovax** **Prevnar**
Have you had a flu shot(s) this season? **YES** **NO**

MEDICATIONS

ARE YOU ALLERGIC TO ANY MEDICATIONS? **YES** **NO** If so, list them and what happens
_____
_____
_____

How long ago was your last reaction _____
Does aspirin, yellow dyes or sodium benzoate cause any problems? **YES** **NO** Which one? _____
Do you take: Circle all that apply Aspirin Arthritis medicine Heart or Blood Pressure medications
Thyroid medicine or have you ever been on any **YES** **NO**
DO YOU TAKE: **Blood thinners** **Beta blockers** **Eye drops** Why do you use eye drops?_____
_____

LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING AND WHAT THEY ARE FOR:

	Drug	**Reason for Drug**	**Doctor who prescribed it**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Are you taking any herbs, vitamins or alternative medicines? **YES** **NO** If so, list them and what they are for:
_____
_____

Have you had previous allergy treatment or testing? **YES** **NO** Doctor's Name _____
When? _____ What type of treatment? _____ Did it help? **YES** **NO**

PHYSICAL AGENTS AND HABITS

Do you use tobacco products**?** **YES** **NO**
Tobacco use for _____ years. Cigarettes _____ packs per day. Chewing tobacco or snuff _____ amount per day _____ Cigars_____ per day Pipe bowls _____ per day.
Do you smoke marijuana? **YES** **NO** Number of joints per day? _____
If you have stopped smoking when did you stop? _____
Do you drink alcohol? **YES** **NO**
Cans of beer _____ per day. **Circle** light or regular 12 oz, 16 oz., 20 oz. 6oz glasses of wine per day ___ Alcoholic drinks _____ per day.
Do you take non-prescribed pills or inject any non-prescribed drugs? **YES** **NO**
Have you had drug or alcohol problems in the past? **YES** **NO**
Do you take sleeping pills or pain killers on a regular basis? **YES** **NO**
Do you do any regular exercise? **YES** **NO** If so, what type? _____
How often? _____ How long at a time _____ minutes.

REVIEW OF SYSTEMS

Do you have or have you ever had thyroid disease? **YES** **NO**
What type? **Circle all that apply** Hypothyroid Hyperthyroid Goiter Cancer
Do you have heart problems? **YES** **NO** What type? **Circle all that apply** Beats irregularly Missed Beats Chest/heart pain Murmur MI
Blood pressure problems? **YES** **NO**
Have you ever had a heart attack? **YES** **NO** If so, when? _____
Do you have problems with your blood? **Circle all that apply** Leukemia Anemia Clotting problems
Have you ever had **Circle all that apply** Stroke Kidney problems Prostate disease Bladder problems
Do you have diabetes? **YES** **NO**
Have you ever had cancer? **YES** **NO** If so, what kind and when _____
Do you have significant problems with your eyes? **YES** **NO** _____
Have you had increased eye pressure (glaucoma)? **YES** **NO**_____
Have you ever had a seizure? **YES** **NO** If yes, explain _____
Have you ever had any significant head trauma? **YES** **NO** If so, what and when? _____
Do you have sick headaches (migraines) **YES** **NO** _____
Do you have any recurrent headaches that wake you out of sleep? **YES** **NO** _____
Do you have any neurological/nervous system problems? **YES** **NO** _____
Do you have any problems with your stomach or GI tract**?** **YES** **NO** _____
Have you had unexpected weight gain or loss? **YES** **NO** _____
Do you have any significant male or female problems? **YES** **NO**_____
Do you get abnormally short of breath when you exercise? **YES** **NO** _____
Do you develop chest pain and difficulty breathing when you exercise? **YES** **NO**_____
Have you been exposed to Tuberculosis? **YES** **NO** _____
Do you have any pulmonary/lung problems not covered above? **YES** **NO** If so, explain_____
Have you had night sweats or unusual fever? **YES** **NO**
Do you have significant arthritis? **YES** **NO** Rheumatological problems? **YES** **NO**
If yes, what type? _____
Do you have other significant muscle, bone or joint problems? **YES** **NO** _____
Do you have any skin problems not covered above? **YES** **NO** If so, explain_____
Have you noticed any enlargement of any of your lymph nodes? **YES** **NO** If so, where? _____
Women: Are you pregnant **YES** **NO** When was your last menstrual period? _____

SLEEP QUESTIONS

Do you or a close blood relative have any of the following problems? Circle Yes or No If yes, write a brief explanation and explain if it pertains to you or your close relative.

1. Do you snore loudly or frequently? **YES NO**_____
2. Do you breathe irregularly or stop breathing during your sleep? **YES NO**_____
3. Have you been told you have pauses in your breathing while you are asleep? **YES NO** _____
4. Are you tired and sleep during the day? **YES NO** _____
5. Do you have a hard time falling asleep? **YES NO** _____
6. Do you wake up in the early morning hours when you want to sleep? **YES NO** _____
7. With emotional situations, such as laughing do you become weak and fall down? **YES NO** _____
8. How many hours a day do you sleep? _____
9. Do you wake up gasping for air? **YES NO**_____
10. Do you sleep with your mouth open? **YES NO** _____
11. Do you sleep with your neck cocked back? **YES NO** _____
12. Are you a very restless sleeper? **YES NO** _____
13. Do your legs creep, crawl or jump around when you are trying to sleep? **YES NO** _____
14. Do you have problems staying awake when you drive? **YES NO** _____
15. Does anyone else in your immediate family have any of those problems? **YES NO** _____
    If the answer is yes, who? _____

16. Do you have a primary care physician? **YES NO** If yes please provide Dr. Bray with the information below:

    Name: _____ Address: _____

    Phone Number: _____

17. Did your primary care physician, physician's assistant, nurse practitioner or any other medical professional refer you to Dr. Bray? **YES NO**

    If yes please provide the name, address and phone number if different than the above. Dr. Bray will provide the medical professional who referred you with a referral letter.

    Name: _____ Address: _____

    Phone Number: _____

THANK YOU FOR BEING THOROUGH IN FILLING OUT THIS DETAILED MEDICAL HISTORY.

OBTAINING A GOOD MEDICAL HISTORY IS FAR AND AWAY THE MOST IMPORTANT THING A PHYSICIAN CAN DO TO MAKE A PROPER DIAGNOSIS. EVERYTHING THAT FOLLOWS IN YOUR CARE DEPENDS ON ITS QUALITY.