Texas Allergy & Breathing Centers

Patient History

Last Name _____First Name_____ Date_____

Sex: M F _____Age_____Marital Status: □S □ M □D □ W Children # _____

Height_____Weight_____BMI_____Neck size_____

Chief Complaint: Please indicate the reason for today's visit (please check)

	Allergies		Cough		Shortness Of Breath		Sleep Evaluation
	Asthma		Cough Blood		Chest Pain		Snoring
	Wheezing		Pulmonary Clearance		Abnormal X-rays		

Smoking History: □ **Never Smoked** □ **Active Smoke** # Pack per Day_____, For_____Years

□ Ex**-Smoker** date quit_____ □ **Second hand smoking**

□ **Do** you or have you ever used □Cigar □Pipe □ Chew tobacco □ Other_____

Alcohol: □None □Quit (year_____). □Active: drinks per day_____ per week_____

□ Drugs Marijuana___ Cocaine____ _Amphetamine____ _IV Drugs_____ Other_____

Occupation: What is your current Occupation_____

Previous Occupation_____

Have you ever worked with □ Asbestos □ Foundry □ Quarry □ Lead □ Mills □ Mines □ Brick plant

□ Solvents □ Acids □ Plastics □ Pottery □ Ceramics □ Dusty Environment □ Other_____

Medication: Do you take any of the following medication please circle

Advair	Flovent	serevent	Spiriva	Foradil	Combivent
Albuterol	Atrovent	Xopenex	Duoneb	nasonex	Flonase
singulair	clarinex/claritin	Zyrtec	Allegra	Theophylline	

Prednisone_____ **mg/day** **Home O2**____**L/min** 24h /day ___Nocturnal **CPAP/ BIPAP**_____**cwp**

ACE Inhibitors **B Blockers**

List all other medication

1 _____ 5_____

2_____ 6_____

3_____ 7_____

4_____ 8_____

Allergy Are you allergic to any **medication**___Pcn___ Sulfa___Aspirin ___other:_____

Do you have **Pets** ___Cat(s)___Dog(s)___Bird(s)___Cattle___Horse___Rabbit ____Other_____

Are you allergic to ___Milk____Eggs___Fish____Shelfish___Nuts____Chocolate____Strawberries____Wheat_____Mushroom

Are you allergic to___ Weeds___ Grass___ Trees__ _Fungus ___Animal dander_ ___House Dust Mite____Insects____Seeds

Have you had **skin allergy test**, if yes When_____Results_____

Review of Systems: do you have any of the following symptoms

□ Nasal discharge	`□ Sinus pain/Pressure	□ Sore throat	□ Fever	□ weight gain
□ Nasal itching	□ Nasal Bleed	□ Mouth Breathing	□ Chills	□ weight loss
□ Nasal congestion	□ Post nasal drip	□ Ear drainage	□ malaise	
□ Sneezing	□ Hoarseness	□ Ear Pressure	□ night sweat	
□ Cloudy Discharge	□ Tonsillitis	□ Ear infection		

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Sputum	Cough	Wheezing	Dyspnea
□ None	□ None	□ None	□ None
□ Thick	□ Daily	□ Every day	□ Walking 1-2 blocks
□ Yellow	□ Night time	□ Every night	□ Walking 100 yard
□ Green	□ Dry/Productive	□ Two nights a week	□ Climbing stairs
□ Bloody	□ Laying flat	□ Two nights a month	□ At Rest
□ Daily for_____days		□ With exercise	□ Laying flat
□ At least 3 months each year		□ Spring/ fall / summer	

Chest Pain: Do you experience chest pain □ At Rest □Exercise □ Night □ Food □ other _____

Does the pain radiate to □ Neck □ Arm □ Back □ Stomach □ Jaw Teeth_____

How long does it last □ Min □ Hrs □ Days _____

Do you have □ Palpitation □ Passing out spells □ Leg pain or swelling?

How many times do you urinate each night _____?

Do you sleep □ Flat □Pillows 2, 3, 4, 5. Do you wake up with shortness of breath Y N _____

Sleep History: Do you experience any of the following symptoms:

□ snoring	□ Witnessed Apnea	□ Loss of libido	□ Leg Restlessness
□ Choking	□ Snoring interrupted by silence	□ Frequent Naps	□ Need to move legs
□ Sleep Talking	□ Day time Sleepiness	□ Night Sweat	□ Repetitive leg movement
□ Sleep Walking	□ falling asleep at inappropriate times	□ Grind your Teeth	□ Depressed
□ Restless Sleep	□ Lack of energy/Fatigue	□ Leg Cramps	□ Irritable/ Short Temper
□ Drowsy Driving	□ MVA related to sleepiness		

Do you have any of the following symptoms:

□ Nausea	□ swallowing difficulty`	□ Painful Urination	□ Headache	□ Joint Pain
□ Vomiting	□ abdominal pain	□ Blood in the Urine	□ Weakness	□ Muscle Pain
□ Heartburn	□ Vomiting Blood	□ Incontinence	□ Numbness	□ Back Pain
□ Diarrhea	□ Rectal Bleed	□ Vaginal Bleed	□ Seizure	
□ Constipation	□ Jaundice		□ Syncope	

Did you ever had TB (tuberculosis) Y N _____

Did you had TB skin test (PPD) Y N _____when_____Results_____mm_____

When the last time you had chest X-ray _____ where_____

Did you have Chest CT scan _____Sinus CT scan_____

Other information_____

_____