

Mary Parkes Center for Asthma, Allergy & Pulmonary Care

(Name) (Date of Birth) (Date)

Reason for consultaion

Have you ever had an asthma, allergy or pulmonary evaluation?
No Yes If yes, When / Where

Have you ever been on allergy shots?
No Yes If yes, When / Where and for how long.

Past medical problems:
1.
2.
3.
4.
5.

Past surgical procedures:
1.
2.
3.
4.
5.

Home Environment Circle all that apply
Apartment House Other:
Pets No Yes Type Access to Your Bedroom Yes No
Mold in the home Yes No
Central Air Conditioning Yes No
Heat Source Gas, Wood stove, Radiator
Fireplace in the home Yes No

Current medications (please include dosage and bring the prescription bottles and inhalers with you at the time of the visit). If you already have a current medication list you can bring that to the visit.

- 1. 2. 3. 4. 5. 6. 7. 8. 9. 10.

Name and telephone of Pharmacy used:

Medication Allergy? Yes No
If yes, please list.

The following diseases have occurred in my immediate family members (grandparents, parents, brothers sisters and children):

Are you currently smoking? No Yes If yes, # of years smoked?
Have you ever smoked? No Yes When did you quit? # years smoked
Have you been exposed to 2nd hand tobacco exposure? Yes No
Do you drink alcohol? No Yes If yes, how much do you drink? Daily Weekly

Describe occupation and work environment:

Social History: Married Single Separated Divorced
Children: No Yes # of children

Please circle whether or not you have had any of the following problems:

GENERAL

Weight Loss Gain _____ Amount in pounds
 Fatigue Yes No
 Weakness Yes No
 Fever/Chills Yes No
 Night Sweats Yes No
 Tremors Yes No

PULMONARY

Short of Breath Yes No
 Wheezing Yes No
 Cough Yes No
 Blood in Sputum Yes No
 Pneumonia Yes No
 Asthma Yes No
 Emphysema Yes No
 Tuberculosis Yes No
 Bronchitis Yes No

GASTROINTESTIONAL

Change in Appetite Yes No
 Nausea / Vomiting Yes No
 Diarrhea Yes No
 Abdominal Pain Yes No
 Burping / Belching Yes No
 Morning Throat
 Hoarseness Yes No
 Ulcer Yes No
 Hiatal Hernia Yes No
 Heartburn Yes No
 Diverticulitis Yes No
 Hepatitis Yes No
 Pancreatitis Yes No

VASCULAR

Calf Pain w / walking Yes No
 Phlebitis Yes No

MUSCULOSKELETAL

Gout Yes No
 Arthritis Yes No

DERMATOLOGIC

Eczema Yes No
 Hives Yes No
 Itching Yes No
 Red Rash Yes No

HEAD, EYES, EARS, NOSE, THROAT

Headaches Yes No
 Blurred Vision Yes No
 Cataracts Yes No
 Glaucoma Yes No
 Buzzing in Ear Yes No
 Hearing Loss Yes No
 Dizziness Yes No
 Sinusitis Yes No
 Nose Bleeds Yes No
 Sore Throat Yes No
 Dentures Yes No
 Snoring Yes No
 Decreased Smell Yes No
 AM Throat Clearing Yes No

CARDIAC

Hypertension Yes No
 Murmur Yes No
 Chest Pain Yes No
 Palpitations Yes No
 Swelling / Legs Yes No

GENITOURINARY

Pain on Urination Yes No
 Frequency of Urination Yes No
 Urination at Night Yes No
 Incontinence Yes No
 Kidney Stones Yes No

NEUROLOGICAL

Numbness / Tingling Yes No
 Loss of consciousness Yes No

ENDOCRINE

Diabetes Yes No
 Thyroid Yes No

HEMATOLOGIC

Anemia Yes No
 Lymph Node Enlargement Yes No

MENTAL HEALTH

Anxiety Yes No
 Depression Yes No

Chest XRAY When _____ Location _____
 Pulmonary Function Test When _____ Location _____

Additional Comments to share with asthma specialist
