

Patient History Form

DO YOU HAVE ALLERGIES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		DO ANY OF YOUR BLOOD RELATIVES HAVE ALLERGIES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		WHAT MEDICATION DO YOU TAKE DAILY OR FREQUENTLY? <input type="checkbox"/> Aspirin <input type="checkbox"/> Vitamins <input type="checkbox"/> Cortisone <input type="checkbox"/> Ointments <input type="checkbox"/> Laxatives <input type="checkbox"/> Nose Drops <input type="checkbox"/> Sedatives <input type="checkbox"/> Hormones <input type="checkbox"/> Birth control pills <input type="checkbox"/> Other (list):		NAME: _____ BY: _____ DATE: _____ NOTES: _____ _____ _____		AGE: _____ SEX: _____	NAME: _____		
CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE OR HAD: <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart disease <input type="checkbox"/> Stomach or intestinal disease <input type="checkbox"/> Overactive thyroid <input type="checkbox"/> Underactive thyroid <input type="checkbox"/> Any hormonal difficulty <input type="checkbox"/> Migraine headache <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Asthma <input type="checkbox"/> Sinus disease <input type="checkbox"/> Emphysema <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Bronchitis <input type="checkbox"/> Broken nose <input type="checkbox"/> Hay fever <input type="checkbox"/> Nasal surgery <input type="checkbox"/> Hives <input type="checkbox"/> Deviated septum <input type="checkbox"/> Skin disease <input type="checkbox"/> Food allergy <input type="checkbox"/> Drug allergy What drugs? _____ <input type="checkbox"/> Other conditions				DO YOU USE MEDICATION REGULARLY FOR NASAL SYMPTOMS? <input type="checkbox"/> Yes <input type="checkbox"/> No What is it? Does it help?		PILLOW: <input type="checkbox"/> None used <input type="checkbox"/> Cotton <input type="checkbox"/> Foam rubber <input type="checkbox"/> Foam rubber <input type="checkbox"/> Feather <input type="checkbox"/> Horse hair <input type="checkbox"/> Dacron <input type="checkbox"/> Feather <input type="checkbox"/> Don't know <input type="checkbox"/> Don't know <input type="checkbox"/> Other <input type="checkbox"/> Other					
CHECK SYMPTOMS YOU USUALLY HAVE: <input type="checkbox"/> Itching of nose <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Nose running <input type="checkbox"/> Sneezing <input type="checkbox"/> Post-nasal drip <input type="checkbox"/> Loss of smell <input type="checkbox"/> Eyes itch <input type="checkbox"/> Throat itch <input type="checkbox"/> Ear infection <input type="checkbox"/> Sore throat <input type="checkbox"/> Cough <input type="checkbox"/> Wheeze				YOUR ENVIRONMENT: OCCUPATION: _____ Prominent materials used: At work, are your symptoms: <input type="checkbox"/> Better <input type="checkbox"/> Worse <input type="checkbox"/> Same AIR CONDITIONING: <input type="checkbox"/> Bedroom <input type="checkbox"/> At work <input type="checkbox"/> Central <input type="checkbox"/> None		HEATING SYSTEM: <input type="checkbox"/> None <input type="checkbox"/> Electricity <input type="checkbox"/> Oil <input type="checkbox"/> Don't know <input type="checkbox"/> Gas <input type="checkbox"/> Other <input type="checkbox"/> Coal		METHOD OF HEAT DELIVERY: <input type="checkbox"/> Hot air blower <input type="checkbox"/> Radiators <input type="checkbox"/> Electric panels <input type="checkbox"/> Don't know		DO YOU USE HUMIDIFIERS? <input type="checkbox"/> Yes <input type="checkbox"/> No	
HOME: <input type="checkbox"/> House <input type="checkbox"/> City <input type="checkbox"/> Apt. <input type="checkbox"/> Country				ARE SYMPTOMS: <input type="checkbox"/> Constant <input type="checkbox"/> Erratic <input type="checkbox"/> Present most of the time <input type="checkbox"/> Present rarely		ANIMALS IN HOME: <u>In past</u> <u>At present</u> <input type="checkbox"/> Dog <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Cat <input type="checkbox"/> Bird <input type="checkbox"/> Bird <input type="checkbox"/> Rodent <input type="checkbox"/> Rodent <input type="checkbox"/> Other <input type="checkbox"/> Other		OTHER ANIMALS YOU FREQUENTLY CONTACT:			
SMOKING HABITS: Cigarettes # _____/day Pipe # _____/day Cigars # _____/day Years Smoked: _____ Stopped smoking _____ (year)				DURING WHAT MONTHS DO YOU USUALLY HAVE SYMPTOMS? <input type="checkbox"/> All months <input type="checkbox"/> Jan <input type="checkbox"/> July <input type="checkbox"/> Feb <input type="checkbox"/> Aug <input type="checkbox"/> March <input type="checkbox"/> Sept <input type="checkbox"/> April <input type="checkbox"/> Oct <input type="checkbox"/> May <input type="checkbox"/> Nov <input type="checkbox"/> June <input type="checkbox"/> Dec		ARE SYMPTOMS WORSE: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> At home <input type="checkbox"/> At work <input type="checkbox"/> Other locations					
ARE YOUR SYMPTOMS: <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe				SOME OF THE FOLLOWING MAY CAUSE YOUR SYMPTOMS OR MAKE THEM WORSE. CHECK THOSE THAT DO: <input type="checkbox"/> Indoors <input type="checkbox"/> Dusty environment <input type="checkbox"/> Road dust <input type="checkbox"/> Vegetables <input type="checkbox"/> Outdoors <input type="checkbox"/> High pollution day <input type="checkbox"/> Chemicals (list): <input type="checkbox"/> Alcoholic beverages <input type="checkbox"/> Weather change <input type="checkbox"/> Animals <input type="checkbox"/> Beer <input type="checkbox"/> Wet weather <input type="checkbox"/> Cooking odors <input type="checkbox"/> Wine <input type="checkbox"/> Dry weather <input type="checkbox"/> Smoke <input type="checkbox"/> Cheese <input type="checkbox"/> Windy day <input type="checkbox"/> Soap powder <input type="checkbox"/> Milk or milk products <input type="checkbox"/> Mushrooms <input type="checkbox"/> Hot day <input type="checkbox"/> Insecticides <input type="checkbox"/> Eggs <input type="checkbox"/> Aspirin <input type="checkbox"/> Cold day <input type="checkbox"/> Paint fumes <input type="checkbox"/> Wheat products <input type="checkbox"/> Drugs (list): <input type="checkbox"/> Air-conditioning <input type="checkbox"/> Perfumes <input type="checkbox"/> Nuts, beans, or seeds <input type="checkbox"/> In barns <input type="checkbox"/> Cosmetics <input type="checkbox"/> Chocolate <input type="checkbox"/> Damp areas <input type="checkbox"/> Wave sets <input type="checkbox"/> Fish <input type="checkbox"/> Hay, circus <input type="checkbox"/> Newspapers <input type="checkbox"/> Meat <input type="checkbox"/> Mowing lawn <input type="checkbox"/> Wool <input type="checkbox"/> Fruit							
DO YOUR SYMPTOMS INTERFERE WITH YOUR LIFE? <input type="checkbox"/> Not at all <input type="checkbox"/> A little <input type="checkbox"/> Moderately <input type="checkbox"/> Prevent many normal activities				DO YOU USE MEDICATION REGULARLY FOR NASAL SYMPTOMS? <input type="checkbox"/> Yes <input type="checkbox"/> No What is it? Does it help?		HEATING SYSTEM: <input type="checkbox"/> None <input type="checkbox"/> Electricity <input type="checkbox"/> Oil <input type="checkbox"/> Don't know <input type="checkbox"/> Gas <input type="checkbox"/> Other <input type="checkbox"/> Coal		METHOD OF HEAT DELIVERY: <input type="checkbox"/> Hot air blower <input type="checkbox"/> Radiators <input type="checkbox"/> Electric panels <input type="checkbox"/> Don't know		DO YOU USE HUMIDIFIERS? <input type="checkbox"/> Yes <input type="checkbox"/> No	

PATIENT NO. _____