ALLERGY & ASTHMA CENTER AT WAXAHACHIE

2460 N. I-35, Suite 220 Waxahachie, Texas 75165
Office (972) 923-9200 Fax (972) 923-9201

SCOT A. LAURIE, MD

DIPLOMATE, AMERICAN BOARD
ALLERGY AND IMMUNOLOGY

Name:_____ Age: _____ Date:_____

Please answer all questions. This information sheet will be reviewed during your visit with your doctor.

1. What is the primary reason for your visit to the office?
   _____
   _____
2. What is your main goal for this visit?
   _____
3. Do we treat any of your family members? If so, can you please tell me their name?
   _____

What symptoms do you have?

1. Nasal symptoms: (If you do not have nasal symptoms, please skip to 2)
   a. Congestion ----------->Yes No
   b. Drainage ----------->Yes No
   c. Sneezing ----------->Yes No
      i. Do you sneeze four or more times in a row?---->Yes No
   d. Itching ----------->Yes No
   e. When did your nasal symptoms begin? _____
   f. Seasonal, or year-round symptoms? _____
   g. If seasonal, what are your worst seasons? _____

2. Respiratory symptoms: (If you have no respiratory symptoms, please skip to 3)
   a. Chest tightness ----------> Yes No
   b. Shortness of breath ----------> Yes No
   c. Wheezing ----------> Yes No
   d. Cough ----------> Yes No
   e. Have you been diagnosed with asthma? ----------> Yes No
      i. If so, when? _____
   f. Have you been hospitalized because of asthma? --------> Yes No
      i. If so, when? _____
   g. Have you visited an emergency room because of asthma? Yes No
      i. If so, when? _____
   h. If you have asthma, what makes your asthma worse? (e.g. exercise, stress, heat or cold, etc)
      _____
      _____

3. Skin symptoms: (If you have no skin symptoms, please skip to 4)
    a. Eczema ----------> Yes No
    b. Hives ----------> Yes No
    c. Swelling ----------> Yes No
        i. What parts of the body does the swelling affect?

        _____

        _____

    d. Rash ----------> Yes No
        i. What parts of the body does the rash affect?

        _____

        _____

4. Eye Symptoms: (If you have no eye symptoms, please skip to question 5)
    a. Itching ----------> Yes No
    b. Watering ----------> Yes No
    c. Redness ----------> Yes No

5. Previous Evaluation
    a. Have you seen a doctor for any of the above problems? Yes No
    b. What are the names of the doctors?

    _____

    _____

    c. What treatments did you try?

    _____

    _____

    _____

    d. Have you been allergy tested? ----------> Yes No
        i. If yes, when, where, and by what doctor?

        _____

        ii. If yes, what were you allergic to?

        _____

        _____

    e. Have you ever taken allergy shots? ----------> Yes No
        i. If yes, when, how long, and with what doctor?

        _____

        _____

6. What medications are you currently taking (please include dose and frequency)

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

7. Please list any reactions to any medications in the past:

_____

_____

8. Environmental

    a. How long have you lived in the area? _____
    b. Where did you live previously? _____
    c. How long have you lived in your current residence? _____
    d. How old is your current residence? _____
    e. Do you have pets? ----------> Yes No
        i. If yes, how many and what kind?

        _____

        _____

    f. Do you have carpeting in your bedroom? ----------> Yes No
    g. Do you have any areas of water damage in your home, or areas of visible mold growth? ----------> Yes No
    h. Are there any smokers in the home? ----------> Yes No

9. Social

    a. What is your occupation? _____
    b. Do you exercise? ----------> Yes No
        i. If yes, what type of exercise do you do and how often?

        _____

        _____

    c. Do you smoke now or have you in the past? ----------> Yes No
        i. If yes, when, how much and for how long?

        _____

    d. Do you have any children or grandchildren, or do you work with any young children? ----------> Yes No

10. Medical History

    a. What other medical problems are you being treated for or have you been diagnosed with?

    _____

    _____

    _____

    b. Have you ever been admitted to a hospital? ----------> Yes No
        i. If so, when and what for?

        _____

        _____

    c. Have you had any operations? ----------> Yes No
        i. If so, what operations?

        _____

        _____

    d. Do allergies or asthma run in your family? ----------> Yes No

i. If so, which family members and what conditions do they have?

_____

_____

11. Review of Systems: Please circle any symptom that bothers you a significant part of the time. You will be given the opportunity to discuss these symptoms with one of our staff.

e. GENERAL: Recent weight change; weakness; fatigue; fever

f. SKIN: lump, sores, itching, dryness, changes in hair or nails

g. HEAD: Headache or head injury

h. EYES: Vision changes, pain, redness, excessive tearing, double vision, blurred vision, glaucoma or cataracts

i. EARS: Hearing changes, tinnitus, vertigo, earaches, infection, discharge

j. NOSE AND SINUSES: Frequent colds, nasal congestion, discharge, nasal itching, sinus trouble, nosebleeds, postnasal drip.

k. MOUTH AND THROAT: Problems with teeth or gums, dentures, sore tongue, frequent sore throat, hoarseness.

l. NECK: Lumps, goiter, pain or stiffness in the neck.

m. RESPIRATORY: Cough, sputum, coughing up blood, wheezing, bronchitis, emphysema, pneumonia, tuberculosis, pleurisy, date of last chest x-ray and result:

_____

n. CARDIAC: Heart trouble, high blood pressure, rheumatic fever, heart murmurs, chest pain or discomfort, palpitations, shortness of breath, shortness of breath when lying down, edema, waking up at night because of shortness of breath.

o. GASTROINTESTINAL: Trouble swallowing, heartburn, appetite, nausea, vomiting, indigestion, change in bowel habits, rectal bleeding, black or tarry stools, hemorrhoids, constipation, diarrhea, abdominal pain, jaundice, liver or gallbladder trouble, hepatitis

p. URINARY: Frequency of urination, frequent urination at night, burning or pain with urination, blood in urine, urgency, reduced urinary stream, dribbling, incontinence, urinary infection, kidney stones.

q. MUSCULOSKELETAL: Muscle or joint pain, stiffness, arthritis, gout, backache.

r. NEUROLOGIC: Fainting, blackouts, seizures, weakness, paralysis, numbness, loss of sensation, tingling, tremors.

s. HEMATOLOGIC: Anemia, easy bruising or bleeding, past transfusions and any reactions to them.

t. ENDOCRINE: Thyroid trouble, heat or cold intolerance, excessive sweating, diabetes, excessive thirst or hunger.

u. PSYCHIATRIC: Nervousness, tension, depression, anxiety, memory problems