Strauss Allergy and Asthma
A Division of
Allied Physicians Group

Today's Date Patient's Name Patient's DOB

Patient's Primary Care Physician Address Phone Number

Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Please take time to complete this questionnaire before your appointment. **Thank you!**

Main reason for today's visit: _____

REVIEW OF ORGAN SYSTEMS: Please check any current and past problems.

___ Abnormal sense of taste or smell
___ Arthritis
___ Blood/Bleeding Disorders
___ Breathing with mouth open at night
___ Cancer
___ Cough, Wheeze or Shortness of Breath
___ Diabetes
___ Dizziness
___ Fever
___ Gastrointestinal Disorder, Heartburn or Indigestion
___ Headaches
___ Heart Disease
___ High Blood Pressure
___ Immunologic Disease
___ Infections Disease (HIV/TB)
___ Insect Allergy
___ Lung Disease
___ Neurological Disorder/Seizures
___ Psychological Disorder/Depression
___ Skin Disease
___ Snoring
___ Thyroid Disorder
___ Unexplained change in weight

What medications are you taking? (include over-the-counter products, vitamins, birth control, and herbal remedies)

Medication	Dose (e.g., mg/pill)	How many times per day

Pharmacy Name & Address: _____ Phone: _____

Have you been hospitalized? Please list approximate dates and reasons:

_____ _____

_____ _____

Have you had surgery? Please list approximate dates and reasons:

_____ _____

_____ _____

Do you have any medication allergies? Yes ____ No ___
If YES please list: _____

Do you have any food allergies? Are there any foods you suspect? Yes ___ No ___
If YES please list: _____

(Over)

Strauss Allergy and Asthma

FAMILY HISTORY (Please indicate family members with any of the following conditions):

	Mother	Father	Sibling
Allergies	□	□	□
Hay fever	□	□	□
Chronic stuffy/runny nose	□	□	□
Sinus problems	□	□	□
Asthma	□	□	□
Allergies to food	□	□	□
Immunologic disorder	□	□	□
Respiratory diseases	□	□	□
Skin disorders	□	□	□
Heart Disease	□	□	□
Cancer	□	□	□
Thyroid disease	□	□	□
Diabetes	□	□	□
High blood pressure	□	□	□
Other _____	□	□	□

ENVIRONMENT:

Do you have pets at home? Yes ___ No ___

If YES, please circle: Cat Dog Bird Other _____

List Breed: _____

Do you smoke? Yes ___ No ___ Have you ever smoked? Yes ___ No ___ Quit Date: _____

How many packs per day? _____ # of years _____

Are there any smokers living in the home? Yes ___ No ___

What type of work do you do? _____

Are you exposed to anything at work that you are concerned may affect your health? _____

_____

When was your last chest x-ray? (Please list date and where it was done) _____

IMMUNIZATIONS:

Are the patient's immunizations up to date: Yes ___ No ___

If NO, please explain: _____

Did you have the influenza vaccine this year? Yes ___ No ___

Who completed this form? _____

Name Relation

In Office Use Only:
Reviewed by: _____