



Wichita Clinic General Patient History Form

Do Not Scan

Name: _____ Age: _____ DOB: _____

Date of Visit: _____

Please answer the following questions and **completely** fill out this form before your appointment. Feel free to bring additional notes or expand on answers. Please try to let us know about the symptoms that trouble you the most and the ones that are the most current, persistent and recurrent. Please bring the completed form to your appointment.

Chief Complaint:

What are the main symptoms or complaints that you want evaluated?

How long have these symptoms been present? _____ Months / Years

Did a doctor refer you for this evaluation? Yes No

If Yes, name of doctor: _____

Current Medications: (Please include inhalers, eye drops, over-the-counter medications, vitamins, creams, ointments, herbal supplements, etc.)

Name of Medication	Dose/Strength	Times a Day	Last Dose (date)
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Drug Reactions – Briefly describe: _____

Past Medical History:

Immunizations Up to Date No Yes Severe Reactions to Immunizations No Yes
Last Tetanus _____ Last Pneumovax _____ Last Flu Shot _____ Last TB Skin Test Neg(-) Pos(+)

Do You Have a Personal Medical History of:

- | | | | |
|---------------------------------------------|-----------------------------------------|----------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> Angina | <input type="checkbox"/> Diverticulosis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis/Lupus | <input type="checkbox"/> Fractures | <input type="checkbox"/> HIV/AIDS | <input type="checkbox"/> Thrombophlebitis |
| <input type="checkbox"/> Blood Transfusions | <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Kidney Infection | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Pancreatitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Poor Blood Clotting | |

Other: _____

Previous Allergy Testing? When _____ Did Allergy Shots Help? No Yes
 Previous Allergy Shots? When to When _____ Reactions to Shots? No Yes

Previous Hospitalizations/Dates _____

Previous Surgeries/Dates _____

Reactions to Anesthetics? No Yes

Social History:

Single Married Divorced Widowed

Name of City/Town: _____

Occupation: _____

Occupational Exposure to: Dusts Fumes Solvents Chemicals Other: _____

Hobbies/Crafts: _____

Children & Students: Attend Daycare Private Sitter Attend School: Where? _____
Grade(s) _____

Drug/Alcohol Use:

Do you drink alcohol? No Yes Beer/Wine Liquor How Much/How Often _____

Do you use "recreational" drugs? No Occasional Frequent

Are you in recovery for alcohol/drugs? No Yes

General Review of Systems/Symptoms and General Health:

General State of Health is: Excellent Good Fair Poor

Medical conditions currently being treated or evaluated: _____

Are you pregnant or trying to become pregnant? No Yes

Recent Lab Tests _____

When _____

Where _____

Family History: Grandparents/Mother/Father/Brother/Sister/Children (Please put **GP, M, F, B, S,** or **C** in appropriate space)

<input type="checkbox"/> Nasal Allergies	<input type="checkbox"/> Migraine Headaches	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Asthma	<input type="checkbox"/> Sinus Disease	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Lupus
<input type="checkbox"/> Eczema	<input type="checkbox"/> Immunodeficiencies	<input type="checkbox"/> Stroke	<input type="checkbox"/> Seizures
<input type="checkbox"/> Food Allergies	<input type="checkbox"/> Drug Allergy (ex. Aspirin)	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Symptoms Like Yours
<input type="checkbox"/> Other: _____			

Smoking & Tobacco History

Never Smoked Currently Smoke Pipe Cigars Cigarettes: Packs/Day _____ Years _____

Chew or Dip: Years _____

Quit Smoking: Years Ago _____ Packs/Day _____ Years as a Smoker _____

Smokers in the Household: How Many? _____ Inside Outside

Exposed to smoke at work, daycare or at sitters

Please Fill Out the Following Section if Patient is a Child

Your relationship to child: _____

Does your child stay in a nursery or at a day care center? Yes No

Does your child have a history of eczema? Yes No

Pregnancy, Labor and Delivery

Place of Birth _____ Age of Mother _____

Were There Any Complications During Pregnancy? Yes No

Pregnancy/Labor/Delivery Normal? Yes No (Please Specify): _____

Birth Weight _____

Did the child have any difficulties breathing shortly after birth, or require a respirator or oxygen? Yes No

Development

Has the child reached normal growth milestones? Yes No

If No answered above, please specify: _____

At what age did the child first sit alone? _____ First walk alone? _____



Wichita Clinic Allergy and Asthma Department Patient Questionnaire

Name: _____ Age: _____ DOB: _____ Date of Visit: _____

HPI & Review of Systems Usually Affected by Allergies

Please check if symptoms are present, recurrent or persistent

Eyes:

- Contact Lenses
- Redness
- Excessive Tearing/Mucus
- Puffiness
- Itching
- Dark Circles Under Eyes

Nose:

- Nasal Stuffiness/Obstruction
- Sniffing
- Loss of Smell
- Discharge
 - Clear/Watery
 - Thick
 - Yellow or Green
- Sneezing
- Rubbing
- Itching
- Nosebleeds
- Polyps
- Afrin/Dristan (OTC) Nasal Sprays
- Mouth Breathing Day? Night?
- Snoring
- Gasping or Choking When Asleep
- Sleep Apnea
- Broken Nose When (or age)? _____
- Nasal Surgery When (or age)? _____

Ears, Mouth & Throat:

- Ear Infections Lump in Throat
- Sore Throat Clearing Throat a lot
- Strep Throat Mucus Stuck in Throat
- Mouth Ulcers Laryngitis/Hoarseness
- Tonsillitis
- Roof of Mouth Itches
- Cleft Lip or Palate
- Tubes in Eardrums When (or age)? _____
- Tonsillectomy When (or age)? _____
- Adenoidectomy When (or age)? _____

Sinuses:

- Pressure
- Post-Nasal Drainage Color _____
- Infections
- Sinus X-Ray or CT Scan (circle)
 - When (or age)? _____
 - Results? _____
- Sinus Surgery When (or age)? _____
- Facial Trauma
- ENT Consultation? Who? _____

Nasal & Eye Symptoms:

Are your nasal and eye symptoms:

- Worse in the AM upon Arising
- Worse at Night
- Worse During the Day
- The Same Throughout the Day
- Affected by Work or School Environment
- Worse When Outdoors

Is there a season(s) to your nasal or eye symptoms?

- Winter
- Spring
- Summer
- Fall
- All Season

____ Symptoms present at all times throughout the Year with worse flare-ups during

- Winter
- Spring
- Summer
- Fall

Cycles of Symptoms:

Bouts of Nasal/Ear/Sinus/Cough symptoms usually

Last for _____ days/weeks

Clear up for _____ days/weeks with treatment

Come back for _____ days/weeks after treatment

Ear Infections:

- More than 3 bouts in the past 6 months
- More than 4 bouts in the past year
- Last bout _____ wks/mos/yrs ago

Sinus Infections:

- More than 3 bouts in the past 6 months
- More than 4 bouts in the past year
- Last bout _____ wks/mos/yrs ago

Infectious Bronchitis or Pneumonia:

(Circle above that apply)

- More than 2 bouts in the past 6 months
- More than 3 bouts in the past year
- Last bout _____ wks/mos/yrs ago

Previous Immune Evaluation:

(Cystic Fibrosis)

Sweat Chloride ___ No ___ Yes

Immunology Evaluation ___ No ___ Yes

- Antibody Levels
- Arthritis Tests
- Lupus Tests

Lungs:

- Croup as a Child
- Bronchiolitis (RSV) as a Child
- Cough Upon Arising in AM
- Cough During Day
- Cough Upon Lying Down at Night
- Cough in Middle of the Night
- Cough Produces Mucus
- Shortness of Breath
- Tightness in Chest
- Wheezing During the Day
- Wheezing During the Night
- Cough or Wheezing (circle)
After Exertion / Sports / Hard Laughter
- Last Chest X-Ray Date _____ Where _____

Frequency of Wheezing:

- Daily Best Estimate _____
- 2-3 Times/week
- 2-3 Times/mo
- 2-3 Times/yr

Fill Out the Following Section if Patient is a Child:

Food History:

Until the Child was 6 Months Old was He/She:

Breast Fed Bottle Fed

At what age was the child first fed:

Milk Formula? _____ Soy Formula? _____

Baby Food? _____ Table Food? _____

Are all foods tolerated? Yes No

Which foods are not? _____

Is there coughing during or following meals? Yes No

Asthma History:

- Previous Diagnosis of Asthma When? _____
- Recent ER Visits for Asthma When? _____
- Hospitalizations for Asthma When? _____
- Intensive Care Unit Admission for Asthma When? _____

On Respirator for Asthma in ICU: No Yes

How Long do Asthma Attacks Last? _____

How Severe are Asthma Attacks? _____

Medications Used for Asthma (Now or in Past):

Respiratory Inhalers Which Ones? _____

Times per Day _____ Per Week _____ Per Month _____ Per Year _____ During the Night? No Yes

Nebulizer Treatments

Times per Day _____ Per Week _____ Per Month _____ Per Year _____ During the Night? No Yes

Oral Steroids/Prednisone/Medrol DosePaks/Steroid Shots, etc.

How Many Times in Past Year? _____

Do You Use or Have:

- Spacing Device With Inhalers
- Peak Flow Meter
- Red/Yellow/Green Zone Method of Asthma Control
- Previous Diagnosis of Chronic Bronchitis or Emphysema

How Many Days School / Work Missed due to Asthma in Past Year _____

Headaches/Neurological/Psychiatric:

Headaches

Part of Head Affected? _____

Frequency _____ Times Per Week _____ Per Month _____ Per Year _____

Duration of Headaches _____ Hours _____ Days

Headache Pain _____ Throbbing _____ Constant

Related to Allergies (Sinuses) Related to Foods/Beverages Related to Food Additives

Worse with Bending Over Worse with Changes in Barometric Pressure (circle)

Worse with Light or Noise (circle) Nausea or Vomiting with Headache (circle)

Awaken from Sleep Preceded by Aura or Warning Previous Diagnosis of Migraine

EEG / CT Scan / MRI (circle) When? _____

Neurology Consult When? _____ Physician? _____

Treatment for Headaches _____

Seizure Disorder

Tension

Fatigue

Depression (Requiring Treatment)

Panic/Anxiety Attacks

Memory Disturbance

Personality Disturbance

Gastrointestinal & Adverse Food Reactions:

- Colic (as Infant) Milk or Lactose Intolerance
- Spitting Up (as Infant) Suspected Food Allergies (List Foods) _____
- Vomiting Known Food Allergies (List Foods) _____
- Diarrhea Swelling of Lips/Mouth with Food (List Foods) _____
- Liver Disease Foods Causing Hives or Welts (List Foods) _____
- Irritable Bowel Syndrome
- Colitis
- Heartburn/Reflux/Acid or Sour Taste

Skin:

- Eczema (rough, red, itchy, dry skin)
Where? _____ Onset? _____ Treatment? _____
- Hives
*If you checked Hives or Swelling of Lips, Tongue, Throat, etc. please complete the **Hives/Swelling** section*
- Swelling of Lips, Tongue, Throat, etc.
*If you checked Contact Allergy please complete the **Contact Allergy** section*
- Contact Allergy
- Dermatology Consult When? _____ Who? _____

Hives or Swelling (Angioedema):

When did hives or swelling first occur? _____
 Are your hives or swelling becoming worse or occurring more often? _____
 What do you suspect is the cause, or can you relate this to a food or medication that you have taken? _____

What size are the individual hive lesions? _____

Please describe any swelling: _____

When you break out in hives or experience swelling, how long does it last? _____

Where on your body do hives break out most often? _____

Where does swelling occur on your body? _____

List the medications you take to control hives or swelling _____

Cholinergic: Do any of these factors cause your hives or swelling to start or worsen

- Heat Exercise Sweating Excitement
- Hot Baths Exertion Emotional Upset

Do you have any of the following with your hives or swelling?

- Headache Listlessness Abdominal Cramps
- Faintness Excessive Sweating Diarrhea

Psychogenic: Do you relate the onset of hives or swelling to a particular episode of emotional upset? _____

Endocrine: Do you have any of the following symptoms?

- Intolerance to Heat or Cold Change in Skin or Hair Thyroid Trouble

Women Only: Are your hives or swelling worse before or during your menstrual period? _____

Have your hives or swelling ever occurred while you were pregnant? _____

Autoimmune Serum Sickness: Are you having any of these symptoms (Check all that apply)

- Frequent Fever Joint Stiffness Enlarged Lymph Nodes
- Loss of Weight Aching or Swelling Muscle Tenderness

Physical Factors: Do any of the following factors cause you skin to itch or burn?

- Cold Heat Water Sunlight Vibration Pressure

Contact Allergies: (circle)

- | | | | | |
|-----------|----------------|-----------|---------|---------|
| Examples: | Poison Oak/Ivy | Clothes | Perfume | Lotion |
| | Shampoo | Materials | Soap | Jewelry |
| | Detergent | Latex | Make-up | |

Do you or have you ever had a contact allergy to anything? _____

When was your first contact reaction? _____

Do you know what caused the reaction? _____

Describe the symptoms you had or have now: _____

Precipitating Factors: Do any of the following cause your symptoms to become worse?

- | | | | |
|-------------------------------------------------|----------------------------------------|---------------------------------------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Respiratory Infections | <input type="checkbox"/> Mowed Grass | <input type="checkbox"/> Strong Odors (perfume, cologne, room fresheners, etc.) | |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Weeds | <input type="checkbox"/> Cosmetics | <input type="checkbox"/> Damp Weather |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Leaves | <input type="checkbox"/> Strong Emotions | <input type="checkbox"/> Dry Weather |
| <input type="checkbox"/> Dogs | <input type="checkbox"/> Trees | <input type="checkbox"/> Foods | <input type="checkbox"/> Windy Weather |
| <input type="checkbox"/> Other Animals | <input type="checkbox"/> Tobacco Smoke | <input type="checkbox"/> Factors at Work | <input type="checkbox"/> Changes in Weather |

Home Environment: (These questions are to help us evaluate exposure to important indoor allergens)

- | | | | | |
|--------------------------------------|---------------------------|---------------------------------------|----------------------------------|---------------------------------------|
| <input type="checkbox"/> House | Age of Dwelling ___ years | Basement: | <input type="checkbox"/> City | <input type="checkbox"/> Woods/Fields |
| <input type="checkbox"/> Apartment | Living There ___ years | <input type="checkbox"/> Dry/Finished | <input type="checkbox"/> Suburbs | <input type="checkbox"/> Creek/Pond |
| <input type="checkbox"/> Mobile Home | | <input type="checkbox"/> Wet/Damp | <input type="checkbox"/> Rural | <input type="checkbox"/> Barn |
| | | <input type="checkbox"/> Crawl Space | | <input type="checkbox"/> Farm Animals |

Heat:

- Central/Forced Air
- Radiators
- Radiant
- Wood or Kerosene

Air Conditioning:

- Central
- Window
- Auto

Other

- Electrostatic Air Filter
- HEPA Air Cleaner
- Humidifier/Vaporizer
- Dehumidifier

Floors: Hardwood/Tile Wall to Wall Carpet Carpet Over Concrete Slab Age of Carpets ___ years

Patient's Bedroom:

Number of Occupants: _____

Number of Beds: _____

- Mattress:** Regular Mattress Box Springs Bunk Beds Water Bed
 Air Mattress Crib Mattress Futon Age of Mattress: _____ years
- Pillows:** Feather Foam Polyester/Dacron Age of Pillows: _____ years
- Bedroom Other:** Down (Feather) Comforter Stuffed Animals: How Many in Room? ___ In Bed? ___
 Pets Sleep in Room Sleep With Windows Open Stuffed Furniture in Bedroom

Pets (Indicate # of each)

- | | | | | | | |
|----------------------------------|----------------------------------|---------------------------------------------|----------------------------------|-------------------------------------|---------------------------------|-------------------------------|
| <input type="checkbox"/> Cats | <input type="checkbox"/> Dogs | Other Pets: <input type="checkbox"/> Rabbit | <input type="checkbox"/> Hamster | <input type="checkbox"/> Guinea Pig | <input type="checkbox"/> Gerbil | <input type="checkbox"/> Fish |
| <input type="checkbox"/> Inside | <input type="checkbox"/> Inside | <input type="checkbox"/> Previous Pets | | | | |
| <input type="checkbox"/> Outside | <input type="checkbox"/> Outside | | | | | |

Insects:

- Cockroaches
- Crickets or Spiders
- House is Sprayed

Other:

- House Plants
- Live Christmas Tree
- Frost Free Refrigerator
- Damp/Moldy Areas

Stinging Insect Reactions/Fire Ant Reactions:

- Never Been Stung/No Reaction After a Sting (Go to Next Section)
- Stung by Bee, Wasp, Yellow Jacket, Hornet, etc.
- Hives All Over
- Loss in Consciousness, Fall in Blood Pressure
- Stung by Fire Ants
- Swelling, Pain, Redness Around Sting Site
- Wheezing, Throat Swelling
- Reactions to Other Insect Stings or Bites (Mosquitoes)

Latex (Natural Rubber) Exposure:

- Blood Donor
- Spina Bifida Surgery
- Wear Latex Gloves Frequently
- Multiple Surgeries (Especially on Urinary Tract)
- You are a Health Care Worker (Medical, Dental, Lab, etc.)

Latex (Natural Rubber) Reactions:

Reactions include redness, itching, swelling, runny nose, wheezing or trouble breathing associated with latex contact

- | | |
|--------------------------------------------------------------------------------------------------------------------|------------------------------------------------------|
| <input type="checkbox"/> Dental Exams | <input type="checkbox"/> Condoms |
| <input type="checkbox"/> Blowing up Balloons | <input type="checkbox"/> Diaphragms |
| <input type="checkbox"/> Medical Exams, Especially Rectal or Pelvic (Vaginal) Exams | <input type="checkbox"/> Other Rubber/Latex Products |
| <input type="checkbox"/> Immediate Redness, Itching or Hives From Rubber Gloves | |
| <input type="checkbox"/> Allergic Symptoms During Hospitalization or Surgery | |
| <input type="checkbox"/> Symptoms in an Infant While Sucking on a Baby Bottle or Pacifier | |
| <input type="checkbox"/> Allergic Symptoms From Eating Banana, Avocado, Chestnuts, Kiwi, Figs, Peaches or Cherries | |
| <input type="checkbox"/> Allergic Symptoms From Ragweed or Bluegrass | |

Check if you have had any of the following problems recently:

- | | | | |
|-------------------------------------------------|-------------------------------------------------|-----------------------------------------------------|---------------------------------------------|
| <input type="checkbox"/> Fever | <input type="checkbox"/> Leg Cramps | <input type="checkbox"/> Weight Loss (unexplained) | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Poor Appetite | <input type="checkbox"/> Painful Joints/Muscles | <input type="checkbox"/> Weight Gain (unexplained) | <input type="checkbox"/> Blood Disease |
| <input type="checkbox"/> Irregular Heartbeat | <input type="checkbox"/> Swollen/Stiff Joints | <input type="checkbox"/> Always Too Warm | <input type="checkbox"/> Loss of Spleen |
| <input type="checkbox"/> Heart Palpitations | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Always Too Cold | <input type="checkbox"/> Trouble Swallowing |
| <input type="checkbox"/> Chest Pain or Pressure | <input type="checkbox"/> Back Pain | <input type="checkbox"/> Change in Periods | <input type="checkbox"/> Bloody Stools |
| <input type="checkbox"/> Heart Murmur | <input type="checkbox"/> Recent Injury | <input type="checkbox"/> Painful/Frequent Urination | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Swollen Ankles | <input type="checkbox"/> Prostate Problems | |