LAKESHORE ALLERGY & ASTHMA – 17770 MACK AVENUE, GROSSE POINTE MI 48230

Name: _____ Birth date_____

Your answers on this form will help your health care provider better understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. If you cannot remember specific details, please approximate. Add any notes you think are important. ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Main reason for today's visit: _____

How did you hear about us/who referred you: _____

Primary Care Physician: _____

Other Physicians: _____

PHARMACY & MEDICATION

Pharmacy name: _____ City where pharmacy is located: _____

Cross streets: _____

Please list any medications you are currently taking ☐ None
Include Over the Counter Medications/Vitamins, ETC

_____

_____

_____

_____

_____

_____

_____

_____

Please use back if more space needed.

IMMUNIZATIONS

☐ None ☐ Unknown

☐ Flu Shot Date: _____ ☐ Pneumonia Shot Date: _____ ☐ Other _____

MEDICATION ALLERGIES

☐ No known drug allergies

List any medications that you are allergic to and how each affects you.

	ALLERGY:	REACTION:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

PAST SURGICAL HISTORY ☐ None

SURGERY:	REASON:	YEAR:
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____

FAMILY HEALTH HISTORY ☐ Adopted ☐ Unknown

RELATION	ALLERGY RELATED HEALTH PROBLEMS
Father	☐ Hay Fever ☐ Asthma ☐ Sinus ☐ Rashes ☐ Drug Allergies ☐ Food Allergies Other: _____
Mother	☐ Hay Fever ☐ Asthma ☐ Sinus ☐ Rashes ☐ Drug Allergies ☐ Food Allergies Other: _____
Please circle:	
Brother/Sister	☐ Hay Fever ☐ Asthma ☐ Sinus ☐ Rashes ☐ Drug Allergies ☐ Food Allergies Other: _____
Brother/Sister	☐ Hay Fever ☐ Asthma ☐ Sinus ☐ Rashes ☐ Drug Allergies ☐ Food Allergies Other: _____
Son/Daughter	☐ Hay Fever ☐ Asthma ☐ Sinus ☐ Rashes ☐ Drug Allergies ☐ Food Allergies Other: _____
Son/Daughter	☐ Hay Fever ☐ Asthma ☐ Sinus ☐ Rashes ☐ Drug Allergies ☐ Food Allergies Other: _____
Other	☐ Hay Fever ☐ Asthma ☐ Sinus ☐ Rashes ☐ Drug Allergies ☐ Food Allergies Other: _____

SOCIAL HISTORY

Occupation/School: _____
Work/School environment exposures: _____
Tobacco:
Smoking Status: ☐ Never ☐ Former ☐ Current Every Day ☐ Current Some Days
☐ Cigarettes - _____ packs/day or week
☐ Chew - _____ /day or week
☐ Cigars - _____ /day or week
Smoked since age _____ # of years _____ Former smoker- Quit when _____
Do/did you have second hand exposure : ☐ Home ☐Work ☐Childhood
Alcohol:
Do you drink alcohol? ☐ None ☐ Occasionally ☐ Regularly
How much? _____ Drinks/day _____ Drinks/week
Drugs:
Do you use recreational or street drugs? ☐ Yes ☐ No ☐ In the past
Specify: _____
Pets in the home? ☐ Yes ☐ No

PAST MEDICAL HISTORY

☐ None

Please check all that apply:

HEENT

☐ Allergies
☐ Glaucoma
☐ Hay Fever
☐ Hearing problems
☐ Vision/eye problems
☐ Other _____

Cardiovascular

☐ Aneurysm
☐ Cardiomyopathy
☐ Congestive Heart Failure
☐ Coronary Heart Disease
☐ Heart Attack (MI)
☐ High Cholesterol/Lipids
☐ Hypertension
☐ Leg/Foot Ulcers
☐ Murmur/Valve Disease
☐ Pacemaker
☐ Palpitations/Arrhythmia
☐ Peripheral Artery Disease
☐ Other _____

Genitourinary

☐ Bladder Problems
☐ Dialysis
☐ Endometriosis
☐ Infertility
☐ Kidney Stones/Disease
☐ Prostate Problems
☐ Recurrent UTI's
☐ Other _____

Psychiatric

☐ Addiction
☐ Alcohol Abuse
☐ Anxiety
☐ Depression
☐ Illicit Drug Use
☐ Psych Illness/Hospitalization
☐ Other _____

Respiratory

☐ Asthma
☐ COPD
☐ Emphysema
☐ Lung Disease
☐ Pulmonary Embolism
☐ Tuberculosis
☐ Other _____

Gastrointestinal

☐ Acid Reflux/GERD
☐ Diverticulitis/Diverticulosis
☐ Hepatitis
☐ Liver Disease
☐ Ulcers
☐ Other _____

Endocrine

☐ Diabetes
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Other _____

Musculoskeletal

☐ Arthritis
☐ Back problems
☐ Chronic Pain
☐ Osteoporosis
☐ Other _____

Neurological

☐ Epilepsy/Seizures
☐ Head Trauma
☐ Headaches
☐ Multiple Sclerosis
☐ Neurologic Disease
☐ Stroke
☐ Other _____

Hematology/Cancer

☐ Anemia
☐ Bleeding Disorder
☐ Blood Clots
☐ Blood Disease
☐ Cancer
☐ Other _____

Skin Disorders

☐ Eczema
☐ Hives
☐ Other _____

Rheumatologic

☐ Fibromyalgia
☐ Gout
☐ Lupus
☐ Osteoarthritis
☐ Rheumatoid Arthritis
☐ Other _____

Sexually Transmitted Diseases

☐ HIV or AIDS
☐ Other STD Issue _____

Sleep

☐ Sleep Apnea
☐ Other _____

Other

☐ Anesthesia Complications
☐ Infectious Disease
☐ Organ Transplant
☐ Serious Illness/Injury
☐ Other _____

Pediatric

☐ ADD/ADHD
☐ Birth Defects/Inherited Disease
☐ Congenital Heart Disease
☐ Develop/Behavior Delay or Disorder
☐ Hospital Admission other than birth
☐ Other _____

REVIEW OF SYSTEMS

Constitutional
- ☐ Significant weight change
- ☐ Fever
- ☐ Change in activity level
- ☐ Fatigue

Eyes
- ☐ Blurry vision
- ☐ Redness
- ☐ Itchiness
- ☐ Swelling
- ☐ Discharge

Ears/Nose/Mouth/Throat
- ☐ Ear pain
- ☐ Hearing loss
- ☐ Sinus pressure
- ☐ Nasal congestion
- ☐ Sore throat
- ☐ Hoarseness

Cardiovascular
- ☐ Chest pain
- ☐ Irregular Heart Beats (palpitations)

Respiratory
- ☐ Cough
- ☐ Wheezing
- ☐ Chest tightness
- ☐ Pain with breathing

Gastrointestinal
- ☐ Difficulty swallowing
- ☐ Abdominal pain/Heartburn
- ☐ Nausea/vomiting
- ☐ Blood in stools

Genitourinary
- ☐ Blood in urine
- ☐ Pain/frequency with urination

Musculoskeletal
- ☐ Joint swelling
- ☐ Muscle aches

Skin
- ☐ Itchiness
- ☐ Dry skin
- ☐ Rash/Hives
- ☐ Swelling

Neurological
- ☐ Weakness
- ☐ Headache
- ☐ Dizziness

Psychiatric
- ☐ Depression
- ☐ Anxiety/Stress
- ☐ Insomnia

Endocrine
- ☐ Increased thirst/drinking
- ☐ Temperature intolerance

Allergy
- ☐ Sneezing
- ☐ Runny nose

ENVIRONMENTAL SURVEY

Dwelling: ☐ House ☐ Condo ☐ Apartment ☐ Trailer Age: _____ How many years lived in: _____

Location: ☐ City ☐ Suburb ☐ Country ☐ Near lake/river Other: _____

Heat: ☐ Forced air ☐ Electric ☐ Steam/Hot water Other: _____

Air Conditioner: ☐ Central ☐Window **Humidifier:** ☐ Furnace ☐ Room Currently working: ☐ Yes ☐ No

Foundation: ☐ Crawl space ☐ Slab ☐ Basement: ☐damp ☐dry ☐finished ☐dehumidifier

Bedroom: ☐ Carpeting ☐ Wood ☐ Tile ☐ Rugs Stuffed animals: # _____

Mattress: Age: _____ Encased ☐ Yes ☐ No ☐ Airbed ☐ Waterbed Other: _____

Feather: ☐ Comforter ☐ Bed ☐ Pillows Encased ☐ Yes ☐ No

Pets: How many pets: _____ ☐ Cat ☐ Dog ☐ Guinea Pig ☐ Hamster ☐ Rabbit Other: _____

Does the pet have free roam of the house or confined? _____

ALLERGY SURVEY ☐ None

	List food:	**Type of reaction:**
Food Allergies	_____	_____
	_____	_____
	_____	_____
	_____	_____

	List insect:	**Type of reaction:**
Insect Bite/ Sting Allergy:	_____	_____
	_____	_____

Latex Allergy ☐ Yes ☐ No **Type of reaction:** _____

	List immunization:	**Type of reaction:**
Immunization Allergies:	_____	_____
	_____	_____
Other:	_____	_____
	_____	_____

Other concerns: _____

_____

_____

Signature: _____ Date: _____