



NAME: _____

AGE: _____

Date of Appointment: _____

ID (For Office Use Only): _____

NEW PATIENT HISTORY (age 12 and older)

Person completing the form: _____

Referred by: _____

What are your main concerns today? _____

Lung function tests are adjusted based on race for accuracy. Please indicate which item best describes you (the patient):

African American Native American Asian Caucasian Hispanic Other

Medication List:

Nasal Allergy

Are you having (allergy) eye, ear, nose, or throat problems: Yes No

How many years have you had symptoms? _____

What are your primary symptoms? _____

Food Allergy

Have food allergies been a problem: Yes No

List foods that are suspicious for allergy: _____

Hives

Have hives been a problem: Yes No

Hives began: _____

Hives appear to be triggered by: _____

Do you have any current medical problems?

No known problem

Current problems: _____

Immunizations

Routine childhood immunizations are up to date: Yes No I don't know

Received Pneumovax (Pneumonia vaccine): Yes No I don't know

Month/Year _____

Tetanus in last ten years: Yes No I don't know

Flu shot in the past year: Yes No I don't know

Month/Year _____

Medication Allergies

No Known Drug Allergies

Current Medicatino Allergies: _____

Surgical History

Please indicate if you have had any of the following surgeries

I have had no surgeries

Family Medical History (List Conditions)

Mother: _____

Father: _____

Siblings: _____

Social History

Marital Status: Single Married Divorced/Separated Widow(er)

Smoking Status: current every day smoker

current some day smoker

former smoker

never smoker

unknown if ever smoked

smoker – current status unknown

Smoking type: Cigar Cigarettes Pipe E-Cigs Vaping

Smoking duration: N/A 1-5 years 6-10 years 11-20 years over 20 years

Maximum packs per day: ½ 1 1 ½ 2 or more

Alcohol: Never Rarely Weekly Daily

Do you primarily work: Indoors Outdoors

Occupation: _____

Other: _____

Pediatric Patients

Child attends: Daycare Preschool School Home school None

Does child have any

brothers or sisters: Yes No

Other: _____

Environmental History

Pets/animals (Indoor): None

Pets/animals (Outdoor): None

Smoke Exposure? _____

Other Concerning Exposures? _____

IF YOU ARE NOT HERE FOR ASTHMA RELATED SYMPTOMS PLEASE DO NOT COMPLETE

Please answer yes or no to each of the following:

ER visits for asthma in past year: Yes No How many in past year: _____

Hospitalized for asthma in past year: Yes No How many in past year: _____

Intensive care unit for asthma: Yes No

Does patient have peak flow meter: Yes No

Had a chest X-ray in the past year: Yes No

If yes: Normal Abnormal

Steroid (Prelone, PediaPred, Prednisone, steroid shots) bursts in past year: 0 1-2 3-5 6-10 over 10

COMPLETE ONLY IF YOU ARE BEING EVALUATED FOR ASTHMA

Patient is 12 years or older

How much of a problem is your asthma when you run, exercise or play sports:

- It's a big problem – I can't do what I want
- It's a problem and I don't like it
- It's a little problem but it's OK
- It's not a problem

During the past 4 weeks:

Have you missed any work or school due to asthma:

- Yes
- No

How much of the time did your asthma keep you from getting as much done at work, school, or at home:

- All of the time
- Most of the time
- Some of the time
- A little of the time
- None of the time

How often have you had shortness of breath:

- More than once a day
- Once a day
- 3-6 times a week
- Once or twice a week
- Not at all

How often did you asthma symptoms (wheezing, coughing shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning:

- 4 or more nights a week
- 2 or 3 nights a week
- Once a week
- Once or twice
- Not at all

How often have you used your rescue inhaler or nebulizer medication (such as albuterol):

- 3 or more times per day
- 1 or 2 times per day
- 2 or 3 times per week
- Once a week or less
- Not at all

How would you rate your asthma control:

- Not controlled at all
- Poorly controlled
- Somewhat controlled
- Well controlled
- Completely controlled

