

ALLERGY & ASTHMA

ADOLESCENT GENERAL HISTORY

JEFFREY R. LEIPZIG, M.D.

Name: _____ Date of Birth: _____ Age: _____

LAST

FIRST

MEDICATIONS:

List current prescription/ non-prescription medications (include vitamins, pain, relievers, oral contraceptives, and cold medicines).

None

ALLERGIES:

Have you had a reaction to latex/ adhesive tape/ rubber? **YES NO**
Have you had hives, skin rash, breathing problems or other allergic reactions to medications? **YES NO** If yes, please specify below:

Name of Medication	Dose (Milligrams)	Frequency (times/ day)
_____	_____	_____
_____	_____	_____
_____	_____	_____

Name of Medication	Describe Allergic Reaction
_____	_____
_____	_____
_____	_____

Please identify other medications you have recently used: _____

Are there other medications that you do not tolerate due to unpleasant side-effects? _____

REVIEW OF SYSTEMS:

Please check **YES or NO** for the following questions, and **CIRCLE** all positive responses when multiple choices are given.

	YES	NO
Do you have problems with recent fever or unexplained weight loss?		
Has your illness seriously affected your school performance?		
Has your illness seriously affected your personal life?		
Does your nose run, get stuffy, or itch? Is your smell and taste normal?		
Are you bothered with a cough or shortness of breath?		
Are you stopped from exercising from shortness of breath, coughing or wheezing? Do you cough up sputum or blood?		
Are you awakened at night with shortness of breath, coughing or wheezing?		
Do you have any serious reactions to bee stings or medication?		
Do you have any serious reactions to foods?		
Have you had pain or stiffness in your joints or back?		
Do you have significant facial pain or headaches?		
Do you have spells, seizures, or trouble moving an arm or leg?		
Do you have any problems with your eyes (double vision or blurred vision)?		
Do you have any problems with diminished hearing, dizziness, or hoarseness?		
Are you aware of any enlarged glands (lymph nodes)?		
Do you experience chest pain/ pressure, rapid or irregular beating of the heart or have known heart problems or heart valve problems?		
Do you suffer from anemia or other blood problems?		
Do you have difficulty eating, drinking or swallowing?		
Are you often troubled by indigestion, heartburn, nausea, vomiting?		
Do you have significant problems with constipation, diarrhea, or recent changes in bowel movements?		
Do you have pain or burning when urinating? Or blood in your urine?		
Do you have a skin rash, sore, excessive bruising or a changing mole?		
Do you often feel cold or hot in a room that is comfortable for others?		
Do you feel you may be at risk for HIV/ AIDS?		
Are you experiencing a stressful situation?		
Do you feel depressed, nervous or tired much of the time?		

PAST MEDICAL HISTORY:

ROS otherwise negative

Have you ever been **HOSPITALIZED**? Yes No Describe: _____

Have you ever been to the **EMERGENCY ROOM**? Yes No Describe: _____

Have you received the following **IMMUNIZATIONS**? UP TO DATE YES, Indicate the approximate year(s) it was given:

- | | |
|---|--|
| Measles <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ | Influenza (flu) within last year <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ |
| Mumps <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ | Pneumococcal (for pneumonia) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ |
| Rubella <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ | Hepatitis B <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ |
| Polio <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ | Tetanus/ Diphtheria within last 10 yrs <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ |
| HIB <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ | Varicella (chicken pox) <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown Year _____ |

Have you ever received a **BLOOD TRANSFUSION**? Yes No If yes, give year: _____

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Indicate whether you ever had a **MEDICAL PROBLEM** and/ or **SURGERY** by checking the appropriate. If you have had surgery, indicate the approximate year(s). Circle the appropriate choice when multiple choices are listed in a question.

1. Abnormal growth or development		1. Eyes	
2. Abnormal chest x-ray(s)		2. Ears	
3. Pneumonia(s)		3. Nose / Sinus	
4. Recurrent Otitis Media (ear infections)		4. Tonsils / Adenoids	
5. Recurrent Sinusitis (sinus infections)		5. Lungs	
6. Skin problems		6. Skin	
7. Recurrent Hives		7. Heart Murmur	
8. Snoring		8. Esophagus or stomach	
9. Mouth breathing		9. Appendix	
10. Wheezing		10. Liver or Gallbladder (hepatitis)	
11. Persistent cough		11. Hernia	
12. Sneezing or itching		12. Kidney or Bladder	
13. Adverse reactions to immunizations		13. Bone, Joint, or Muscle	
14. Adverse reactions to foods		14. Back, Neck, or Spine	
15. Other		15. Brain	

SOCIAL HISTORY:

Do you use **tobacco** now? **YES NO** Type and daily amount _____ How long? _____
 In the past? **YES NO** Type and daily amount _____ How long? _____ Year quit
 Do you use **alcoholic** beverages? **YES NO** Type and daily amount _____ How long? _____
 In the past? **YES NO** Type and daily amount _____ How long? _____ Year quit
 Do you use **caffeine**? **YES NO** Type and daily amount _____
 Do you participate in physical activity? **YES NO** Type and daily amount _____

FAMILY HISTORY: Are you adopted? NO YES Other members of family with allergies, asthma, skin problems.

Parents: _____ Siblings: _____

ENVIRONMENTAL HISTORY:

1. Do you live in an older or newer home, or apartment? Year built _____ How long have you lived there? _____
2. What type of air conditioning do you have? (central, window unit) Are you better in air conditioning? <input type="checkbox"/> NO <input type="checkbox"/> YES
3. What type of heating do you have? (gas, electric, steam, wood burning, oil, etc.)
4. Do you have a dog? # _____ Inside / Outside _____ In bedroom? _____ Worse around dogs? _____
5. Do you have a cat? # _____ Inside / Outside _____ In bedroom? _____ Worse around cats? _____
6. Do you have other indoor / outdoor animals? _____ Are you exposed to roaches? _____
7. What type of bedding do you sleep on? (boxspring and mattress, waterbed, etc.)
8. What type of pillow do you have? (feather, foam, polyester)
9. Does your child use dust mite proof covers on bedding? <input type="checkbox"/> No
10. What type of flooring is in your bedroom? (carpet, area rug, hardwood)
11. Do you have a damp basement?

Parent / Patient Comments

REVIEWED BY _____ DATE _____

REV 05272008