**BIRMINGHAM ALLERGY & ASTHMA SPECIALISTS, PC**

**HISTORY & PHYSICAL**

NAME:________________________________________

APPOINTMENT DATE:__________________________

DATE OF BIRTH:________________________________

PRIMARY CARE PHYSICIAN: ___________________

REFERRED BY: ________________________________

***TO BE COMPLETED BY PATIENT***

Please describe in your own words the reason for this visit.

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

**CURRENT MEDICATIONS:** Please list all medications, both prescribed by a physician and obtained without a prescription (over the counter), that you are currently taking.

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

***TO BE COMPLETED BY PHYSICIAN***

**CHIEF COMPLAINT:**

**HISTORY OF PRESENT ILLNESS:**

NAME:________________________________

APPOINTMENT DATE:__________________

***TO BE COMPLETED BY PATIENT***

**Medical History:**

1. Have you ever had nasal or sinus surgery?

   [ ] Yes [ ] No

   Type:

   Date(s):

2. Have you had a tonsillectomy or adenoidectomy?

   [ ] Yes [ ] No

   Date(s):

3. Have you had ear tubes?

   [ ] Yes [ ] No

   Date(s):

4. Have you ever been tested for allergy?

   [ ] Yes [ ] No

   If so, did you have skin tests/ RAST (blood) tests?

   [ ] Yes [ ] No

5. Have you ever had allergy injections

   [ ] Yes [ ] No

   If so, please give dates:

   Did they help?

6. List all drug allergies:

7. List all food allergies:

8. Have you ever had a severe reaction to a bee sting or an ant bite?

   [ ] Yes [ ] No

   Describe:

***TO BE COMPLETED BY PHYSICIAN***

**ASSOCIATED SYMPTOMS:**

**Nasal** Itchy Runny Congested Sneezing
Snoring Mouthbreather Nosebleeds

**Sinus:** Headache Pressure Infections

**Ear:** Itchy Popping OM Hearing Loss

**Eye:** Itchy Runny Swelling Redness

**Throat:** Itchy PND Hoarseness Strep Clearing

**Chest:** Cough Wheeze Tightness SOB

**Skin:** Itchy Hives Eczema

**Palate:** Itchy

**Infections/yr:**

**Abx/yr:**

**Steroids/yr:**

**Family History**

| | Mother | Father | Sibling | Other |
|---|---|---|---|---|
| **Rhinitis:** | | | | |
| **Sinus:** | | | | |
| **Asthma:** | | | | |
| **Hives:** | | | | |
| **Eczema:** | | | | |
| **Migraines:** | | | | |
| **Rheum:** | | | | |
| **Immunodef:** | | | | |

**Siblings:** ______________________________
______________________________
______________________________
______________________________

**Children:** ______________________________
______________________________
______________________________
______________________________

NAME:______________________________

APPOINTMENT DATE:________________

***TO BE COMPLETED BY PATIENT***

**Check the following medical conditions that you have currently or have had in the past**

| | Current | Past |
|---|---|---|
| Eye Disease | [ ] | [ ] |
| Nasal Polyps | [ ] | [ ] |
| Emphysema | [ ] | [ ] |
| Croup | [ ] | [ ] |
| Heart Disease | [ ] | [ ] |
| Mitral Valve Prolapse | [ ] | [ ] |
| Gastroesophageal Reflux | [ ] | [ ] |
| Ulcers | [ ] | [ ] |
| Colitis or Diverticulitis | [ ] | [ ] |
| Bladder Infections | [ ] | [ ] |
| Prostate Problems | [ ] | [ ] |
| Arthritis | [ ] | [ ] |
| Migraines | [ ] | [ ] |
| Seizures | [ ] | [ ] |
| Depression | [ ] | [ ] |
| Anxiety | [ ] | [ ] |
| High Blood Pressure | [ ] | [ ] |
| Diabetes | [ ] | [ ] |
| Thyroid Disease | [ ] | [ ] |
| Cancer | [ ] | [ ] |
| Other: | [ ] | [ ] |
| | [ ] | [ ] |
| | [ ] | [ ] |

**Please list all hospitalizations (including year & reason)**

1.

2.

3.

4.

***TO BE COMPLETED BY PHYSICIAN***

**PHYSICAL EXAM:**

WT:__________ HT:__________
T:__________ P:__________ BP:__________

**GENERAL APPEARANCE:**

**EYES:** Conjuntiva – Normal R L; Red R L
Lids – Normal R L; Edema R L
Shiners Dennie's Lines

**EARS:** TMS – Normal R L; Dull R L ; Red R L
Canals - Normal Occluded

**NOSE:** Nasal Crease
Mucosa - Normal Pale Red
Edema – R - Mild Moderate Severe
L - Mild Moderate Severe
Mucous – Mild Moderate Copious
Mucoid Serous
Polyps - None ; Present R L
Septum – Midline ; Deviated R L
Perforated Excoriated R L

**ORPHARYNX:** Palate – Normal Other:
Post Pharynx - Normal Injected
Cobblestoned PND

**TEETH & GUMS:** Normal Other:

**FACE/SINUS TENDERNESS:** Absent Frontal Maxillary

**NECK:** Normal Appearance

**THYROID:** Normal Enlarged

**LYMPHATICS:** Neck Axilla Groin

**CHEST:** Ventilation - Normal Retractions

*PRE* Auscultation - Normal
Wheezes R L Bilat
Rhonchi R L Bilat

*POST* Auscultation - Normal
Wheezes R L Bilat
Rhonchi R L Bilat

NAME:______________________________________

APPOINTMENT DATE:_______________________

***TO BE COMPLETED BY PATIENT***

**For children under 15, complete the following:**

1. Birth Weight:___________________________
2. Were there any complications following delivery?
   [ ] Yes [ ] No
   Explain:
3. Has growth and development been normal?
   [ ] Yes [ ] No
   Explain:
4. Are immunizations up to date?
   [ ] Yes [ ] No

**Social History:**

Current Occupation:_______________________________

(if applicable): Mother's Occupation:_______________
Father's Occupation:________________

Marital Status:
[ ]Single [ ]Married [ ]Divorced [ ]Widowed
[ ]Significant Other [ ]Life Partner

Smoking History:

[ ]Current [ ]Past Started/How long_____________

**Environmental History:** (Please check the appropriate boxes)

Home: [ ]House [ ]Apartment [ ]Condo
[ ]Mobile Home Age of Home___________
Pets: [ ]Cat [ ]Indoor [ ]Outdoor
[ ]Dog [ ]Indoor [ ]Outdoor
[ ]Other [ ]Indoor [ ]Outdoor
Smokers in the home: [ ]None

[ ]Indoors by _________ [ ]Outdoors by__________

Heat: [ ]Central [ ]Radiator

Air conditioning: [ ]Central [ ]Window

Pillows: [ ]Feather [ ]Non-feather Age:______

Bed: [ ]Mattress/Boxspring [ ]Waterbed

[ ]Bunkbed Top Bunk____ Bottom Bunk____

Age:____________

Flooring: [ ]Hardwood [ ]Carpet Age:_________

Basement or Crawlspace:

[ ]Dry [ ]Damp [ ]Musty

***TO BE COMPLETED BY PHYSICIAN***

**Physical Exam (continued):**

**CVS**: Heart-
PV (observ/palp)-

**ABDOMEN**: Tenderness Mass
Liver/Spleen – Normal Enlarged

**EXTREMITIES**:

**SKIN**: Normal Lichenified Excoriated
Oozing Erythema Wheals
Papules Dermatographic

**NEURO/PSYCH**: Orientation -
Mood/Affect -

**OTHER:**

**NOTES:**