ALLERGY & ASTHMA CENTER
OF NORTHERN NEW JERSEY

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HEALTH HISTORY FORM

Patient's name: _____ Date: _____

Your answers on this form will help us better understand your medical concerns and conditions. Please take the time to complete this questionnaire before your appointment. **Thank you!**

Main reason for today's visit: _____

_____

REVIEW OF ORGAN SYSTEMS: (Please check any current and past problems.)

- ◯ Abnormal sense of taste or smell
- ◯ Arthritis
- ◯ Blood/bleeding disorders
- ◯ Breathing with mouth open at night
- ◯ Cancer
- ◯ Cough, wheeze or shortness of breath
- ◯ Diabetes
- ◯ Dizziness
- ◯ Fever
- ◯ Gastrointestinal disorder, reflux
- ◯ Difficulty swallowing, choking
- ◯ Migraine headache
- ◯ High blood pressure
- ◯ Immunologic disease
- ◯ Recurrent or chronic infections
- ◯ Insect allergy
- ◯ Neurological disorder/seizures
- ◯ Lung disease
- ◯ Psychological disorder/depression
- ◯ Skin disease
- ◯ Snoring, sleep disorder
- ◯ Thyroid disorder
- ◯ Unexplained change in weight
- ◯ Heart disease

What medications are you taking? (Include over-the-counter products, vitamins, birth control, and herbal remedies.)

MEDICATION:	DOSE (e.g., mg/pill):	HOW MANY TIMES PER DAY?

Have you been hospitalized (other than surgeries)? (Please list approximate dates and reasons.)

DATE:	REASON:

Have you had surgery? (Please list approximate dates and reasons.)

DATE:	REASON:

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Patient's name: _____

HEALTH HISTORY FORM, CONT.'D

Do you have any medication allergies? ◯ No ◯ Yes (specify medication) _____

Do you have any food allergies? ◯ No ◯ Yes (list food) _____

Are there any foods you suspect? ◯ No ◯ Yes (list food) _____

FAMILY HISTORY: (Please indicate family members with any of the following conditions.)

	MOTHER	FATHER	SIBLING		MOTHER	FATHER	SIBLING
Allergies	◯	◯	◯	Skin disorders	◯	◯	◯
Hay fever	◯	◯	◯	Heart disease	◯	◯	◯
Chronic stuffy/runny nose	◯	◯	◯	Cancer	◯	◯	◯
Sinus problems	◯	◯	◯	Thyroid disease	◯	◯	◯
Asthma	◯	◯	◯	Diabetes	◯	◯	◯
Allergies to food	◯	◯	◯	High blood pressure	◯	◯	◯
Rheumatoid/immunologic disease	◯	◯	◯	Angioedema (swelling)	◯	◯	◯
Respiratory diseases	◯	◯	◯	Other _____	◯	◯	◯

ENVIRONMENT:

Do you have pets at home? ◯ No ◯ Yes / Type of pet(s): _____

Where do you live? ◯ Private house ◯ Apartment ◯ Condominium Year built: _____

What type of heating system? ◯ Forced air ◯ Radiator ◯ Baseboard

Your bedroom has: ◯ Wall-to-wall carpeting ◯ Area rug ◯ Other (specify) _____

Do you smoke? ◯ No ◯ Yes / How many packs per day? _____ # of years: _____

Have you ever smoked? ◯ No ◯ Yes / Quit date _____ Are there any smokers living in the home? ◯ No ◯ Yes

What is your occupation? _____

For students, where do you attend? _____

Are you exposed to anything at work that you are concerned may affect your health? _____

_____

When was your last chest x-ray? (Please list date and where it was done.) _____

IMMUNIZATIONS:

Are the patient's immunizations up to date? ◯ Yes ◯ No (explain) _____

Did you have the influenza vaccine this year? ◯ Yes ◯ No

Who completed this form? Name: _____ Relation to patient: _____