MEDICAL INFORMATION

NAME:	DATE OF BIRTH:

LOCAL PHARMACY:

LIST PRESCRIBED MEDICATION AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

MEDICATION, STRENGTH & HOW OFTEN:	6.
1.	7.
2.	8.
3.	9.
4.	10.
5.	11.

ALLERGIES TO MEDICATIONS OR FOODS	REACTION YOU HAD	REACTION TO BEE, HORNET, WASP OR MOSQUITO
1.		
2.		
3.		
4.		

LIST MEDICAL PROBLEMS OR PRIOR DIAGNOSED DISEASES OR ISSUES

LIST HOSPITALIZATIONS

YEAR	SURGERIES	ER VISIT	HOSPITALIZATION OVER NIGHT STAYS

PAST ALLERGY THERAPY

YEAR:	WHAT KIND OF TESTING:	IMMUNOTHERAPY: Y N # YEARS:	OTHER THERAPY:

MEDICATION S THAT HAVE BEEN TRIED & FAILED:

FAMILY HEALTH HISTORY	PLEASE LIST WHAT FAMILY MEMBER
ALLERGIES	
ARTHRITIS	
ASTHMA	
CANCER (WHAT KIND)	
COPD	
DIABETES	
ECZEMA	
HEART ATTACKS/STROKES	
HYPERTENSION	
IBS/COLITIS	
MIGRAINES	
REFLUX	
THYROID	
OTHER:	

HEALTH HABITS

Do you drink alcohol? Y N What kind? How many drinks per week?	Exposed to second hand smoke? Past Present None
	Do you use tobacco? Past Present Year Quit None
Do you currently use recreational or street drugs? Y N	Cigarettes – pks #/day Chew - #/day Cigars- #/day
Past and Present Occupation:	Exercise: Minutes a week: Type:
Marital Status: M S W D	

ALLERGY & ASTHMA CENTER OF THE ROCKIES

Environmental History

NAME:	DOB:

HOME

- WHAT TYPE OF HOME DO YOU LIVE IN? SINGLE FAMILY APARTMENT TOWNHOUSE; OWN RENT
- AGE OF HOME?_____
- HOW MANY YEARS HAVE YOU LIVED AT THIS RESIDENCE?_____
- WHAT OTHER PARTS OF THE COUNTRY HAVE YOU LIVED IN?_____
- HEATING SYSTEM? FORCED AIR OIL HOT WATER ELECTRIC WOOD STOVE FIREPLACE
- COOLING SYSTEM? AIR CONDITIONER SWAMP COOLER OPEN WINDOWS
- DO YOU HAVE A HUMIDIFIER? YES NO
- IS YOUR HOME MOSTLY CARPETED? YES NO
- WHERE IS YOUR HOME LOCATED? RURAL URBAN SUBURBAN
- DO YOU HAVE WATER DAMAGE OR MILDEW IN THE HOME? YES NO

BEDROOM

- DO YOU HAVE BEDDING OR FURNITURE MOVED HERE FROM ANOTHER PART OF THE COUNTRY? YES NO
  IF YES, WHICH STATE?_____
- DO YOU HAVE CARPETING OR LARGE RUGS IN THE BEDROOM? YES NO
  IF YES, WHAT TYPE ARE THEY? COTTON WOOL SYNTHETIC
- DO YOU HAVE A DOWN COMFORTER? YES NO

BED

- ARE YOU SLEEPING ON A BED ON THE FLOOR? YES NO
- WHAT IS YOUR MATTRESS MADE OUT OF? FOAM FEATHERS SYNTHETIC
- WHAT IS YOUR PILLOW MADE OUT OF? FOAM FEATHERS
- DO YOU HAVE EXTRA PILLOWS ON YOUR BED? YES NO
- DO YOU HAVE STUFFED ANIMALS ON YOUR BED? YES NO

INDOOR PETS

- DO YOU HAVE ANY PETS WITH FUR OR FEATHERS? YES NO
  IF YES, WHAT TYPE? DOG CAT BIRD HAMSTER RABBIT OTHER_____
- DO YOUR PETS SLEEP IN YOUR BED OR BEDROOM ON THE FLOOR? YES NO
- DO YOU HAVE OUTDOOR ANIMALS? YES NO

SMOKING HISTORY

- HAVE YOU EVER SMOKED? YES NO
  IF YES, HOW MANY YEARS_____ PACKS PER DAY_____
- DO YOU CURRENTLY SMOKE? YES NO
- ARE YOU READY TO QUIT SMOKING? YES NO
- HAVE YOU BEEN EXPOSED TO SECOND HAND SMOKE? YES NO
  IF YES, HOW MANY YEARS?_____

OCCUPATION / ACTIVITIES

- AT WORK WHAT ARE YOU EXPOSED TO? SMOKE DUST CHEMICALS FUMES FARM PRODUCTS ANIMALS
- WHILE DOING YOUR DAILY ACTIVITIES ARE YOU EXPOSED TO THESE AS WELL? YES NO
- WHAT HOBBIES DO YOU HAVE?