Allergy, Asthma & Sinus Center, P.A.

Gurdev S. Judge, MD   Stephen Begley, P.A.-C

Board Certified in Allergy and Immunology - Pediatrics and Adult

Cary
401 Keisler Drive, Suite #201,
Cary, NC 27518
T: (919) 859–5966 F: (919) 859–4993

North Raleigh
10931 Raven Ridge Road, Suite #111,
Raleigh NC 27614
T: (919) 870–6440 F: (919) 859–4993

Wake Forest
1906 S. Main Street, Suite #216,
Wake Forest NC 27587
T: (919) 562–7195 F: (919) 859–4993

Patient's Name: ______________________ **DOB:** __________ **Age:** ________

Date of visit: ______________ Referring physician's Name: __________________ ____

Main reason(s) for your visit: ____

____

Please circle current & past symptoms   **Family member our patient?** Yes No

Nose: itchy, sneezing, runny, stuffy, mouth breathing, ↓ smell, snoring, nosebleeds

Sinuses: headaches, facial pain, post-nasal-drip, frequent sore throat, hoarseness, loss of voice

# of sinus infections/year? ______________ Date of last sinus x-ray: ____________

Eyes: itchy, watery, red, swelling/puffiness, pain, dark circles, glaucoma, cataract

Ears: itchy, pain, popping, fullness, recurrent infections, dizziness, ringing, hearing loss

Since how long you have above symptoms? ________ Worse? ____ days / mo / yr(s)

Cough: dry hacking, productive of sputum **Worse:** at night, morning, all the time, laughing, exercise

Chest: shortness of breath, chest tightness, wheezing, chest congestion, chest pains, colds end up in chest, cough or wheeze at night, cough or wheeze with exercise, asthma, bronchitis, pneumonia

Have you ever been diagnosed with asthma? If yes, how long ago? ____________________

How often do cough or wheeze? _______ # of ER visits: ____ # of hospitalizations: _______

Date of last chest x-ray? ________________ was it normal? __________________

Does asthma restrict your physical activity (exercise, housework, yard work, etc): ____________

Do you use any inhaler before exercise? ______Type of regular exercise: ________________

Stomach: indigestion, gas, sore throat, hoarseness, throat tightening, heartburn, GERD, hiatal hernia,

Food allergy: (list if any) ____

Insect allergy: (list if any) ____

Skin: general itching, rash, hives, swelling, eczema, poison ivy, earrings, nickel, latex glove allergy

Headaches: sinus, tension, migraine, associated with menses **Since when & how often?** ________

Location? forehead, temple area, behind eyes, back of head

Associated symptoms: nausea, vomiting, vision changes, sensitivity to light or sound

Triggers: allergies flare-up, stress, weather changes, cigarette smoke, strong odors, menses

Medications, which helped: ____

Other: poor sleep, excessive fatigue, sadness, worthlessness, low concentration, restlessness

Duration of allergy symptoms? ______________**worse since when?**________________

Do allergies interfere with your life style? ____________________________________

Number of school or workdays missed in the past year due to sickness: __________________

Previous skin testing & treatment: Yes No

When, where & by whom? ____

Main positive reactions: ____

Received allergy shots? ________ How long? _______ # of shots each visit? __________

Are you currently on shots? _______Were shots helpful? _______ Any reactions? ________

Aggravating factors: (please circle)

Seasonality: spring, summer, winter, fall, year around

Location & time of the day: at home, at work, in the morning, in the evening, at night

Allergic: house dust, pollens, mowing grass, raking leaves, cat, dog, birds, horses

Weather: cold dry, hot humid, sudden temp. change, rainy days, infections, "colds"

Irritants: cigarette smoke, strong odors, perfumes, cosmetics, paints, cleaning products

Others: foods, food additives, dried fruits, wine, beer, Aspirin, Motrin, β-blocker

All Current Medications:

Medication's Name	Dose	Times a day	How long	Side effects

List All Previous Medications: ____

____

Have you ever taken? Steroid dose pack (Prednisone), OTC nose drops, flu shot, pneumonia shot

Allergic or Adverse Drug Reactions: ____

____

Surgeries: tonsillectomy, adenoidectomy,septoplasty, sinuses, ear tubes

Other surgeries: ____

Hospitalizations (when, where & why): ____

Current Environment :

Where were you born & raised? ____________________ # of years living in the current home: ___________

Other states or countries you have lived in: ____

Dwelling type? house, apartment, mobile home, other Age of the dwelling? __________ Years

Pets in the house? __________ Cats, __________ Dogs, ________Birds, Other ________________________

Are pets? outdoors, indoors, allowed in the bedroom & bed

Are your symptoms worse with exposure to pets? _______________ Relatives with pets? ________________

House has: carpet, hardwood, area rugs, damp basement, air conditioner, forced air heat, fireplace, air cleaner, humidifier, dehumidifier, mattress/boxsprings, water bed, feather pillows, down comforter, pillows encasing, mattress encasing, many indoor plants, stuffed animals

Is there any obvious mildew in the house? __________________ or around the house? __________________

Smoker in the house , if yes who? ____

Work related exposure: asbestos, silica, chemicals, fumes, dust, animals, latex gloves, other

Family History: please √

	Mother	Father	Brothers	Sisters	Children	Aunts	Uncles	Grandparents
Hay Fever								
Sinusitis								
Asthma								
Bronchitis								
Emphysema								
Eczema								
Hives								
Food Allergy								
Migraine								
Insect Allergy								
Hypertension								
Glaucoma								
Tuberculosis								

Social History:

Marital status: ______________________ Number of children if married: ______________________________

Occupation: Current: _________________________________ Previous: _________________________________

Smoking? If yes, # of packs a day: ____________ # of years? __________ If quit when? _________________

Number of cups of coffee in a day: _________________ Tea: ____________ Soda: ______________________

Hobbies/Activities: ____

If adult female: Are you pregnant? ____________ Are you currently planning pregnancy? _______________

Rash / E czema / Hives or Urticaria: (please go to next section if no rash)

Since how long do you have rash? ____________________ if worse, since when? _______________________

Is your rash? pruritic (itchy), tingling, burning, painful, constant, intermittent

What par ts of your body are typically affected? scalp, face, neck, chest, abdomen, back,

arms, legs, hands, feet, Other: ____

Swelling of any body parts (lips, eyes or tonge) with rash? ____

Did you have any difficulty in breathing with rash ? ____

How long it takes for the rash to appear? sudden, gradual, over minutes, over hours, over days

How long it takes for the rash to disappear? over minutes, over hours, over days, never disappear

Associated symptoms? fever, chills, diarrhea, headache, weight loss, heat or cold intolerance

Have you used any new: soap, detergent, cosmetics, perfume or clothes before the rash? _______________

Were you sick, or had a cold like symptoms before the rash? ____

Do you suspect any foods? ____

Do you suspect any drug or medication? ____

Triggers: stress, heat, sun light, sweating, exercise, cold, cold water, latex contact, foods,

detergents, soaps, make-up, perfumes, deodorant, new clothes, minor trauma, not sure

REVIEW OF SYSTEMS

PLEASE CIRCLE THE ONES THAT APPLY

Const. (Health in General) No Problems Lack of energy, unexplained weight gain or weight loss, loss of appetite, fever, night sweats, pain in jaws when eating, scalp tenderness, prior diagnosis of cancer. Other: ______________________________

Ears, Nose, Mouth & Throat No Problems Difficulty with hearing, sinus problems, runny nose, post-nasal drip, ringing in ears, mouth sores, loose teeth, ear pain, nosebleeds, sore throat, facial pain or numbness. Other: ______________________________

C-V (Heart & Blood Vessels) No Problems Irregular heartbeat, racing heart, chest pains, swelling of feet or legs, pain in legs with walking. Other: ______________________________

Resp. (Lungs & Breathing) No Problems Shortness of breath, night sweats, prolonged cough, wheezing, sputum production, prior tuberculosis, pleurisy, oxygen at home, coughing up blood, abnormal chest x-ray. Other: ______________________________

GI (Stomach & Intestines) No Problems Heartburn, constipation, intolerance to certain foods, diarrhea, abdominal pain, difficulty swallowing, nausea, vomiting, blood in stools, unexplained change in bowel habits, incontinence. Other: ______________________________

GU (Kidney & Bladder) No Problems Painful urination, frequent urination, urgency, prostate problems, bladder problems, impotence. Other: ______________________________

MS (Muscles, Bones, Joints) No Problems Joint pain, aching muscles, shoulder pain, swelling of joints, joint deformities, back pain. Other: ______________________________

Integ. (Skin, Hair & Breast) No Problems Persistent rash, itching, new skin lesion, change in existing skin lesion, hair loss or increase, breast changes. Other: ______________________________

Neurologic (Brain & Nerves) No Problems Frequent headaches, double vision, weakness, change in sensation, problems with walking or balance, dizziness, tremor, loss of consciousness, uncontrolled motions, episodes of visual loss. Other: ______________________________

Psychiatric (Mood & Thinking) ☒ No Problems Insomnia, irritability, depression, anxiety, recurrent bad thoughts, mood swings, hallucinations, compulsions. Other: ______________________________

Endocrinologic (Glands) No Problems Intolerance to heat or cold, menstrual irregularities, frequent hunger/urination/thirst, changes in sex drive. Other: ______________________________

Hematologic (Blood/Lymph) No Problems Easy bleeding, easy bruising, anemia, abnormal blood tests, leukemia, unexplained swollen areas. Other: ______________________________

Allergic/Immunologic No Problems Seasonal allergies, hay fever symptoms, itching, frequent infections, exposure to HIV. Other: ______________________________