Utah Valley Ear, Nose & Throat
Glen T. Porter, MD, FAAOA
1159 E. 200 N. Ste 325
American Fork, UT 84003

New Patient Medical History and Allergy Survey

Please complete this form. It is important for your doctor to know the details about your medical history and allergy symptoms. If you have questions about completing this form, please ask the medical office staff.

Name: _____ Age _____ Date _____

Primary Care Physician's Name: _____

Referring Physician's Name: _____

Chief complaint(s) and onset:

_____
_____
_____

Expectations from this allergy/immunology consultation: _____
_____

Do you have any of the following:

Asthma Yes____ No____ Uncertain____ Date of Onset_____
Exercise induced asthma Yes____ No____ Uncertain____ Date of Onset_____
Allergies/hayfever Yes____ No____ Uncertain____ Date of Onset_____
Hives/Urticaria Yes____ No____ Uncertain____ Date of Onset_____
Rash Yes____ No____ Uncertain____ Date of Onset_____
Eczema Yes____ No____ Uncertain____ Date of Onset_____
Food allergy Yes____ No____ Uncertain____ Date of Onset_____
Drug allergy Yes____ No____ Uncertain____ Date of Onset_____
Insect allergy Yes____ No____ Uncertain____ Date of Onset_____
Headache Yes____ No____ Uncertain____ Date of Onset_____
Anaphylactic reaction Yes____ No____ Uncertain____ Date of Onset_____
Other (please describe): _____
_____

Allergy evaluation:

Have you ever been evaluated by an allergist/immunologist? Yes_____ No_____
Name of previous allergist:_____ Date last seen:_____
City/State of previous allergist:_____
Have you had any "blood work" to determine if you have allergies? Yes____ No____
Have you ever been "skin tested" to evaluate allergies? Yes_____ No_____ Uncertain_____
If "yes", what were you allergic to (check all that apply):
Trees____ Grasses____ Weeds____ Cat____ Dog____ Dust mites____ Molds____
Cockroaches____ Food____
Have you ever been on "allergy injections/immunotherapy"? Yes_____ No_____ Uncertain_____
If "yes": When did you start:_____
How long did you receive immunotherapy?_____
Did you find it beneficial? Yes_____ No_____ Uncertain_____
Did you have any significant reactions after injections: No___ Yes___ Describe:_____

Nasal and Eye Allergy Symptoms:

Onset of Allergy symptoms (age): _____
How long have you lived in Utah? _____
Where have you previously lived? _____

Do you have daily symptoms: Yes ____ No _____ Seasonal _____
Are your allergy symptoms getting worse: Yes _____ No _____ Constant_____
What time of year are your allergy symptoms worst (check all that apply):
Spring _____ Summer _____ Fall _____ Winter _____
Do any particular exposures make your allergies worse (check all that apply):
Cats ____ Dogs ____ Smoke ____ Grass ____ Perfume _____ Strong odors _____
Other allergy triggers: _____
How is your sense of smell: Excellent____ Good ____ Poor _____ None _____
Do you have discolored nasal discharge? Yes____ No____
If yes, what color and how long have you had it? Color:_____ Onset:_____
Check all allergy symptoms that you have:
Eyes: Itching___ Swelling___ Burning ___ Runny ___ Watery___ Discharge___ Pain___
Ears: Itching___ Fullness___ Popping___ Decreased hearing___ Pain___
Nose: Itching___ Sneezing___ Runny nose___ Congestion___ Stuffy nose___ Obstruction___
Mouth breathing___ Nasal pressure or pain___ Nasal polyps___
Throat: Itching___ Soreness___ Post nasal drip___ Throat clearing___ Swelling___
Do you currently use a nasal spray? Yes____ No____ Name:_____
Do you currently use an antihistamine? Yes____ No____ Name:_____
Do you ever use nasal saline spray? Yes_____ No_____ Never_____
Do you use nasal saline irrigation? Yes_____ No_____ Never_____
Do you use "Afrin" or other over the counter nasal decongestant spray? Yes___ No___ If "yes", for how long:_____
Have you ever had a CT (CAT scan) of your sinuses? Yes____ No____
If "yes", Date/results:_____
Have you ever had sinus surgery? Yes_____ No_____ If "yes", when:_____
Have you been evaluated by an ENT/Otolaryngolagist? Yes___ No___ If "yes", who and when:_____

Respiratory:
Do you cough? Yes____ No ____ Onset of cough: _____
Do you wheeze? Yes___ No____ Onset of wheezing:_____
Have you ever been diagnosed with any of the following:
Asthma: Yes_____ No_____ Age of diagnosis:_____
COPD: Yes_____ No_____ Age of diagnosis:_____
Emphysema: Yes_____ No_____ Age of diagnosis:_____
Pneumonia: Yes_____ No_____ How many times:_____ Age of diagnosis:_____
Bronchitis: Yes_____ No_____ Age of diagnosis:_____
Do you cough at night? Yes_____ No_____ How many times per month:_____
Do you wheeze at night? Yes_____ No_____ How many times per month:_____
Do you cough with activity? Yes_____ No_____ How many times per month:_____
Do you wheeze with activity? Yes_____ No_____ How many times per month:_____
What activities cause you to cough or wheeze (check all that apply):
Walking___ Walking up stairs___ Running___ Exercise___
Do you cough when you laugh? Yes_____ No_____
Have you had a chest X-ray? Yes____ No____ Date/results:_____
Have you had a chest CAT Scan? Yes____ No____ Date/results:_____
Have you had lung function testing? Yes____ No____ Date/results:_____
Do you currently use "Albuterol"? Yes____ No____ Nebulizer____ Meter dose inhaler_____
How many times per week do you use Albuterol?_____
Do you use any other respiratory medications? Yes____ No____
Have you used any of the following medications (check all that apply):
Advair___ Flovent___ Pulmicort___ Asmanex___ Qvar___ Foradil___ Serevent___
Combivent___ Singulair___ Albuterol___
If "yes", did any of the medications help your breathing: Yes___ No___ Uncertain___
Which medications helped you the most (check all that apply):
Advair___ Flovent___ Pulmicort___ Asmanex___ Qvar___ Foradil___ Serevent___
Combivent___ Singulair___ Albuterol___
What triggers your respiratory symptoms (check all that apply):
Upper respiratory infection____ Change in weather___ Exercise___ Cold weather___
Hot weather___ Wind___ Smoke___ Strong odors____ Perfume____ Work related____

Have you ever been intubated or on a ventilator? Yes____ No____
Have you ever been admitted to the ICU or PICU? Yes____ No____
How many times in your life have you been on oral steroids:_____
When was your last course of oral steroids:_____
Have you ever had a "Bone density" study? Yes____ No____
Do you have osteopenia? Yes____ No____ Do you have osteoporosis? Yes____ No____
Do you use a peak flow meter? Yes___ No___ If "yes", what is your best peak flow (liters/min):_____

Eczema:

Have you ever been diagnosed with eczema? Yes____ No____ (If "No", go to next section)
Age at onset of eczema? _____
Triggers of eczema (check all that apply):
Food allergy____ Milk____ Egg____ Nut____ Cat____ Dog____ Dry weather____ Cold weather____
Grass exposure____ Swimming pool____ Bathing____ Other:_____
Do you use daily moisturizer? Yes_____ No_____
Do you use a topical steroid? Yes____ No____
Have you ever had a severe skin infection requiring antibiotics? Yes____ No____ How many times? _____
Do you have a dermatologist? Yes_____ No_____ Name of physician:_____
Have you been evaluated for food allergy? Yes____ No____

Drug Allergy:

If "no known drug allergies", place check next to none and proceed to next section: None_____
Please list all drug allergies, date, and reaction(s)
1. Drug: _____ Date/Age:_____ Reaction:_____
2. Drug: _____ Date/Age:_____ Reaction:_____
3. Drug: _____ Date/Age:_____ Reaction:_____
4. Drug: _____ Date/Age:_____ Reaction:_____
5. Drug: _____ Date/Age:_____ Reaction:_____
6. Drug: _____ Date/Age:_____ Reaction:_____
7. Drug: _____ Date/Age:_____ Reaction:_____

Food Allergy:

If "no known food allergies", place check next to none and proceed to next section: None_____
Please list all food allergies, date, and reaction(s)
1. Food: _____ Date/Age:_____ Reaction:_____
2. Food: _____ Date/Age:_____ Reaction:_____
3. Food: _____ Date/Age:_____ Reaction:_____
4. Food: _____ Date/Age:_____ Reaction:_____
5. Food: _____ Date/Age:_____ Reaction:_____
Do you have an EpiPen or EpiPen Jr? Yes____ No____
Have you ever used your EpiPen or received epinephrine? Yes____ No____ Uncertain____
Have you ever been seen in the Emergency Room for food allergy: Yes____ No____
Are you familiar with the Food Allergy and Anaphylaxis Network? Yes____ No____

Environmental History:

Do you live in a: House____ Condo____ Apartment____ Mobile Home____ RV____ Assisted living____
Other_____
Do you have any pets? Yes____ No____
If "yes", how many of the following: Cats_____ Dogs_____ Hamsters____ Ferrets____ Birds____ Snakes____
Are the pets allowed inside the bedroom? Yes____ No____
Do you have carpeting in the bedroom? Yes____ No____
Do you use a humidifier? Yes____ No____ Do you use central air conditioning? Yes____ No____
Do you use a HEPA filter? Yes____ No____ Do you use an "Ionic Breeze" or similar? Yes____ No____
How many people live with the patient (number): _____
Who lives with the patient (i.e. mom, dad, wife, etc.):
_____
Does anyone who lives with the patient smoke? Yes____ No____
Does anyone smoke in the house? Yes____ No____ Does anyone smoke in the car? Yes____ No____

Birth History: (Only to be completed if the patient is < 10 years old)
Place of birth (city/state):_____
Full term: Yes____ No____ If "No", how many gestational weeks:_____
Check type of birth: Vaginal birth _____ OR C-Section _____
Birth Weight: _____
Did the baby stay in the NICU? No____ Yes_____ If "yes", for how long?: _____ Ventilator? Yes____ No____
Complications: No ____ Yes____ If "Yes", please describe:_____
Breast fed: Yes___ No___ If "yes", for how long:_____
Formula type: Cow's milk based____ Soy___ Lactose Free___ Nutramigen___ Alimentum___ Other_____
Age started solid foods:_____

MEDICATIONS
Please list all current medications and reason for taking:
1. _____ Reason for taking: _____
2. _____ Reason for taking: _____
3. _____ Reason for taking: _____
4. _____ Reason for taking: _____
5. _____ Reason for taking: _____
6. _____ Reason for taking: _____
7. _____ Reason for taking: _____
8. _____ Reason for taking: _____
9. _____ Reason for taking: _____
10. _____ Reason for taking: _____

Please list all over the counter and herbal/vitamins that you are taking:
1. _____ Reason for taking: _____
2. _____ Reason for taking: _____
3. _____ Reason for taking: _____
4. _____ Reason for taking: _____
5. _____ Reason for taking: _____
6. _____ Reason for taking: _____
7. _____ Reason for taking: _____
8. _____ Reason for taking: _____

PAST MEDICAL HISTORY
Operations/Surgery (Name and date of procedure)
1. _____
2. _____
3. _____
4._____
5. _____

Hospitalizations (Where, reason, date, and length of stay)
1. _____
2. _____
3. _____
4. _____
5. _____

Medical Problems (Problem and date diagnosed)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Social History: (Adults and adolescents)
Do you smoke (check all that apply)? Yes____ No____ Never_____ Quit _____
If "yes", how much do you smoke? _____ packs per day Age started:_____
If you "Quit", when did you quit? _____ How many years did you smoke? _____
How many packs did you smoke per day (average)?_____
Are you exposed to "passive smoke" from another household member? Yes___ No___
Do you drink alcohol? Yes____ No____
Average drinks per day: _____ Type of alcohol: Beer___ Wine___ Liquor___
Do you use "recreational drugs"? Yes___ No___ If "yes", what type:_____
Do you consider yourself at "high risk" for HIV? No___ Yes___ If "yes", why:_____
Caffeine use (drinks/day):_____
Occupation:_____
Exposure to toxic or noxious chemical/substances: No____ Yes____ Describe:_____

Social History: (If < 13 years old)
Is the patient exposed to "passive smoke" from another household member? Yes___ No___
Daycare: Yes____ No____ If "yes", age started attending:_____
School: Yes____ No____ Grade:_____ Performance: Excellent___ Good___ Fair___ Poor___

Family History
Are there any members of the immediate family who have asthma, hay fever, eczema, rash, food allergies, drug allergies, insect allergies, arthritis, recurring and/or frequent infections? Please list and comment.
_____
_____
_____
_____
Are there any hereditary diseases or other disorders that seem to occur frequently in your family (diabetes, emphysema, heart
problems)?
_____
_____
_____
_____

Review of Systems

Do you currently have any of the following? (Check)

Allergy
___Asthma
___Hay fever
___Drug allergy
___Food allergy
___ Insect allergy
___Recurrent infections
___Recurrent ear infections
___Recurrent sinus infections
___Recurrent pneumonia

Nose/Throat
___Nasal congestion
___Sneezing
___Itchy nose
___Runny nose
___Discolored nasal discharge
___Nosebleeds
___Post nasal drip
___Nasal obstruction
___Sore throat
___Hoarseness
___Itchy throat
___Frequent throat clearing
___Throat swelling

Derm
___Hives
___Eczema
___Swelling
___Rash
___Itching
___Dry skin
___Suspicious lesions

General
___Fever
___Chills
___Night sweats
___Poor appetite
___Fatigue/Weakness
___Weight loss
___Weight gain
___Sleep disorder
___Headaches
___Facial pain

Cardiovascular
___Chest pains
___Palpitations
___ Chest pain with exercise
___Ankle swelling
___Heart attack in the past

Respiratory
___Cough
___Cough at night
___Wheezing
___Wheezing at night
___Wheezing w/activity
___Discolored sputum
___Coughing up blood
___Snoring

Eyes
___Eye itching
___Eye swelling
___Eye burning
___Eye tearing
___Eye discharge
___Eye irritation
___Vision loss
___Eye pain
___Photophobia

Psychiatric
___Anxiety
___Depression
___Other psychiatric problems

GI
___Diarrhea
___Constipation
___Abdominal pain
___Heart burn
___Nausea
___Difficulty swallowing
___Vomiting

Ears
___Itchy ears
___Ear pain
___Ear discharge
___Ringing
___Decreased hearing
___Popping of ears
___Fullness of ears

Reviewed form with the patient in its entirety.

_____
Glen T. Porter, M.D.