DuPage Medical Group
ASTHMA & ALLERGY CENTER

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Dr. Jacqueline Moran Dr. Brian Smart Dr. Thomas Van Osdol

Patient History (Adult) Pt. Name:

Please take a few moments to complete the following **two page** patient questionnaire. Thank you.

Primary Care Provider: _____ **Referred by:** _____

What medical concerns would like addressed during today's visit (Chief Complaint)?

_____

Please list your current and past **medical problems** and any prior **surgeries**:

_____

_____

Please list your current **medications** including dosages (if known). Please include any supplements, herbs, vitamins, etc.

_____

_____

_____

_____

MEDICATION ALLERGIES:

_____

ENVIRONMENTAL ALLERGIES:

Please help us get to know you and your home environment a little better.

Personal History:

Marital status:_____
Children:number/ages_____

Occupation (s):_____
_____
_____

Alcohol use: ☐**Yes** ☐**No**
Tobacco/smoking history:
1. Previous use: ☐**Yes** ☐**No**
   Quit date:_____
2. Current use: ☐**Yes** ☐**No**
   If "yes," are you interested in quitting?
   ☐**Yes** ☐**No**
3. Packs per day/years:_____

Hobbies/Interests:
_____
_____

Home Environment:

Live in: apt, house etc..._____
Indoor animals: ☐**Yes** ☐**No** List:_____
_____
Indoor smokers: ☐**Yes** ☐**No** List:_____
History of indoor water damage and/or indoor mold:
☐**Yes** ☐**No**

If yes, explain: _____
_____

Do *you* use "dust mite covers" for bedding:
☐**Yes** ☐**No**
Heating and cooling (central or window AC, gas or electric heat, fireplace etc.):_____
_____
Flooring (carpet, laminate, tile, wood, etc.):_____
_____

FAMILY MEDICAL HISTORY:

Do immediate family members have any of the conditions listed below (do not include yourself)?

Condition:	**Family history:**	**Who (i.e. mother, father, siblings, children, etc):**
Allergies	☐**Yes** ☐**No**	
Sinus problems	☐**Yes** ☐**No**	
Asthma	☐**Yes** ☐**No**	
Other lung disease	☐**Yes** ☐**No**	
Eczema	☐**Yes** ☐**No**	
Thyroid problems	☐**Yes** ☐**No**	
Autoimmune disease	☐**Yes** ☐**No**	
Immune deficiency	☐**Yes** ☐**No**	
Migraines	☐**Yes** ☐**No**	
Other	**Explain:**	

REVIEW of SYSTEMS:

Please **check Yes or ~~No~~** to indicate if you ***currently*** have any problems in one or more of the following areas. If yes, please circle and/or briefly explain the problem.

Organ system:	**Yes or No**	**If yes, please circle all that apply:**
General health:	☐**Yes** ☐**No**	Recurrent fever, chills, sweats, unexplained weight loss, weight gain, excessive fatigue, sleep problems
Eyes:	☐**Yes** ☐**No**	Blurred vision, eye pain, eye discharge, redness, watering, matting/crusting, itching, gritty sensation, eyelid rash/swelling
Ears/nose/throat:	☐**Yes** ☐**No**	Hearing loss, earache, nasal congestion, nose bleeds, abnormal taste/smell, nasal drip, post nasal drip, allergies, dry mouth, sores in mouth, sore throat, hoarseness, throat clearing
Cardiovascular:	☐**Yes** ☐**No**	Irregular heart beats, hypertension, heart problems, stroke
Respiratory:	☐**Yes** ☐**No**	Asthma, emphysema, chronic bronchitis, cough, wheezing, shortness of breath, exercise difficulties
Gastrointestinal:	☐**Yes** ☐**No**	Reflux/heartburn, difficulty swallowing, nausea, vomiting, diarrhea, constipation, ulcers
Genitourinary:	☐**Yes** ☐**No**	Painful urination, frequent urination, incontinence due to coughing
Musculoskeletal:	☐**Yes** ☐**No**	Arthritis, joint pain, muscle pain, cramps, joint stiffness, joint swelling
Skin:	☐**Yes** ☐**No**	Dryness, rashes, itching, redness, swelling, change in moles
Neurology:	☐**Yes** ☐**No**	Headache, numbness/tingling, weakness, dizziness, lightheadedness
Psychiatry:	☐**Yes** ☐**No**	Anxiety, depression
Endocrine:	☐**Yes** ☐**No**	Excessive thirst, cold intolerance, diabetes
Hematology:	☐**Yes** ☐**No**	Anemia, bleeding problems, enlarged lymph nodes

Physician Notes: _____

_____

_____

_____

_____

_____

☐ I have reviewed the information above.

_____

Physician Signature Date