ALLERGY & ASTHMA CLINICS OF OHIO

PERSONAL, FAMILY AND ENVIRONMENTAL HISTORY

Patient Name: _____ Patient Date of Birth: _____

Office Where Seen: _____ Date of Examination: _____

***Family History*:**

ASTHMA	RHINITIS/HAY FEVER	DERMATITIS	AUTOIMMUNE DISEASE
Father	Father	Father	Father
Mother	Mother	Mother	Mother
Sibling	Sibling	Sibling	Sibling
Paternal Grandparent	Paternal Grandparent	Paternal Grandparent	Paternal Grandparent
Maternal Grandparent	Maternal Grandparent	Maternal Grandparent	Maternal Grandparent
None	None	None	None

Environmental History (PLEASE CIRCLE YOUR ANSWER):

Residence Location: Urban Rural Suburban

Type of Residence: Apartment House Mobile Home

Smokers In Residence: No Yes

Basement? No Yes
If yes Damp Dry

Air Conditioning? Central Window Unit None
Dehumidifier Humidifier

Heating System Forced Air Radiator Space Heater
Fireplace
None **How often are furnace filters changed?** _____

Type of Floors Living Area Carpet Wood Vinyl Other
Bedroom Carpet Wood Vinyl Other

Type of Bed Waterbed Mattress Encased? Yes No
Box Spring Encased? Yes No

Type of Pillows Feather Polyester Foam
Cotton Encased? Yes No

Pets No Pets Dog Cat
Bird Other
Pets Located: Outdoor Indoor Bedroom

Current Occupation? _____
Are you exposed to occupational antigens? Yes No
Any previous exposure to occupational antigens? Yes No

Past Allergy Workup Done? Yes No

If yes, results? Drug Allergy? _____ Insect Allergy: _____

If yes, by whom? _____ **If yes, when?** _____

Past Immunotherapy? Yes No
If yes, results? _____

Personal Medical History

Diabetes	Reflux	Hypertension	Heart Murmur	Thyroid	Bronchial Asthma

Personal Surgical History

Sinus	Ear Tubes	Tonsils	Adenoids