

DIET: Regular: _____		Special Diet: _____	
FAMILY MEDICAL HISTORY: (Note: Allergy, Asthma, or Chronic lung disease)			
	Age:	Health Status:	
Father			
Mother			
Siblings			
Children	Age:	Health Status:	
Any on-going or significant past illness for you? _____			
SMOKING HISTORY: <input type="checkbox"/> None <input type="checkbox"/> Cigarettes <input type="checkbox"/> Cigars <input type="checkbox"/> Pipe <input type="checkbox"/> Chewing tobacco <input type="checkbox"/> Live with smoker No. of years _____ Packs per day _____ Cigarettes per day _____ Quit (year) _____			
PETS: <input type="checkbox"/> Dog (s) <input type="checkbox"/> Cat (s) <input type="checkbox"/> Rodents <input type="checkbox"/> Reptiles <input type="checkbox"/> Fish <input type="checkbox"/> Bird (s) <input type="checkbox"/> others			
PERSONAL MEDICAL HISTORY: <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart disease <input type="checkbox"/> Heartburn / Ulcers <input type="checkbox"/> Diabetes <input type="checkbox"/> Stroke <input type="checkbox"/> Gastric reflux <input type="checkbox"/> Others _____			
Past Surgeries	Year	Hospitalizations	Year
ER / Urgent Care Visits for what & when? _____			
Number of Emergency visits for asthma, bronchitis, pneumonia in the past? _____			
Number of school/work days missed in the past twelve months? _____			
DID you have: Influenza Vaccine <input type="checkbox"/> Yes year _____ <input type="checkbox"/> No			
Pneumonia Vaccine <input type="checkbox"/> Yes year _____ <input type="checkbox"/> No			
HOBBIES/INTERESTS:			
YOUR SKIN: <input type="checkbox"/> Dry skin <input type="checkbox"/> Hives <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> other _____			
YOUR EARS : <input type="checkbox"/> Frequent ear infections <input type="checkbox"/> Tubes <input type="checkbox"/> Hearing loss <input type="checkbox"/> Hearing aide <input type="checkbox"/> other			
YOUR NOSE : Date of last CT of Sinuses if any: _____ (check all that pertain)			
<input type="checkbox"/> Seasonal symptoms?	<input type="checkbox"/> Symptoms worse in the morning ?	<input type="checkbox"/> Snores	
<input type="checkbox"/> Year round symptoms?	<input type="checkbox"/> Mouth breather?	<input type="checkbox"/> Frequently sneezes	
<input type="checkbox"/> Frequent Sinus Infections	<input type="checkbox"/> Symptoms with Pet exposure	<input type="checkbox"/> Nasal polyps?	

