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Infants, Children and Adults

MEDICAL HISTORY

Date of Service: _____

PATIENT'S NAME: _____ Date of Birth: _____

****NOTE:** Please fill out this form as it *applies to the patient*. Not everything will apply to everyone.

List **ALL** allergies or bad reactions to **MEDICATIONS**:

List **ALL** allergies or bad reactions to contact with **plants, jewelry or cosmetics**:

List the main problem(s) and symptoms for which you are seeing us.

How long have the symptoms been going on? _____

Circle **One**: my symptoms are: **getting better** **staying the same** **getting worse**

Have you ever seen an allergist before? Yes/No _____ Who? _____

When? _____ Where? _____

Have you had any previous allergy tests, blood tests, x-rays, done in the past? _____

If so, please bring a copy or have your doctor fax a copy of the most recent reports to our office at: **(904) 378-8199**.

Have you taken allergy shots in the past? Yes/No _____ When? _____

Was there any improvement? Yes/No _____ Bad Reactions? _____

When was your last tetanus shot? _____

Do you get a flu shot regularly? Yes/No _____ Any bad reactions? _____

Have you ever had a Pneumovax shot? Yes/No _____ When? _____

Have you ever had a Hepatitis B series? Yes/No _____ When? _____

Have you ever received a gammaglobulin (shot or IV)? Yes/No _____ When? _____

Have you ever had a blood transfusion? Yes/No _____ When? _____

Circle **ALL** diseases that you have had:

Chicken pox **measles** **mumps** **scarlet fever** **mono/EBV** **5ths disease** **RSV** **rotavirus** **hepatitis**

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MEDICAL HISTORY (continued)

PATIENT'S NAME: _____ **Date of Birth:** _____

How long have you lived in your present city? _____ Lived in present home? _____

If you have ever lived in another state please indicate the state _____

Were your symptoms: better ____ worse ____ no different ____

List all surgeries and the year performed: (tonsillectomy, ear tubes, heart surgery, etc.) _____

Have you ever been hospitalized? _____ Overnight? _____

If yes, state the reason: (childbirth, surgery, asthma, dehydration, etc.) _____

In the past 5 years have you had an emergency room visit OTHER THAN for minor accidents or injuries?

SYMPTOMS

Do symptoms affect: daily living _____ ability to work _____ to attend school _____ limit physical activity _____

How many days have you missed school/work in the past 12 months? _____

Do you miss: 1-2 days at a time ____ OR longer times less often ____

In the past 5 years have you had any of the following symptoms listed below?

Please respond in relation to how you are **WITHOUT** medication. **Circle all that apply.**

■ **Eyes:** itching (lids or eyes), tearing (watery), dry, red, sensitive to light, puffiness, swelling, dark under the eyes, glaucoma, cataracts, wear glasses, wear contacts, recent eye exam.

■ **Ears:** itching, chronic fluid, recurrent infections, earaches, decreased hearing (intermittent or progressive), ringing in ears, hearing aid, ear tubes, drainage, dizziness.

■ **Nose:** stuffy, runny, mucus (clear or discolored), itchy, sneeze attacks, sinusitis (frequent or chronic), crusting, nose bleeds, loss of smell, bad odor, frequent rubbing of nose, snoring, stop breathing during sleep, nasal polyps, post nasal drainage, frequent throat clearing, sniffing, snorting.

■ **Mouth-Throat:** bad taste, bad breath, recurrent ulcers, recurrent cold sores, coated tongue, sore tongue, bad teeth, root canals, braces, dentures, frequent sore throat, recurrent tonsillitis, hoarseness (frequent or chronic) swelling (lips, tongue, throat), "lump in throat", itchy roof of mouth, swollen neck glands.

■ **Endocrine:** Diabetes, thyroid, other: _____

MEDICAL HISTORY (continued)

PATIENT'S NAME: _____ **Date of Birth:** _____

SYMPTOMS (continued)

- **Chest:** ribs caved in or pushed out, chest pain, (left-sided, under breast bone, with activity, with cough or wheeze attacks)
- **Breasts:** pain, cystic, tumor, implants, surgery.
- **Lungs:** cough (chronic, attacks, with exertion, lying down, produces mucus, produces blood), short of breath without exertion, cough or wheeze follows nasal flare, chronic bronchitis, seasonal bronchitis, recurrent pneumonia, night sweats, emphysema, wheeze (attacks, chronic-daily, weekly, seasonal), with exertion, with colds, props on 2 or more pillows to sleep, cough or wheeze AM's, wakes during night, COPD, limitation of activity (sports, climbing stairs, walking fast, need special work environment).
- **Heart:** congenital defect, chronic, murmur, irregular heart beat, mitral valve prolapse, heart failure, high blood pressure, high cholesterol, sensitive to stimulants (caffeine, decongestants, e.g. Sudafed).
- **Abdomen:** heartburn, reflux, ulcers, frequent bloating, cramps, loose stools (occasional, chronic), irritable bowel syndrome, colitis, polyps, diverticulosis, hemorrhoids, frequent nausea, recurrent vomiting, chronic constipation, lactose (milk sugar) intolerance, irritable/sweaty/weak if long time without eating, recent large weight gain or loss.
- **Genito-urinary:** recurrent bladder infections, urinary frequency and/or urgency, urinary burning, blood in urine, bed wetting, incontinence, sexually transmitted disease, genital or rectal rashes.
Women: recurrent yeast infections, ever use birth control pills, planning on getting pregnant soon, irregular menstrual cycle, PMS (are you on any medication to treat this? _____), do allergies worsen before your period? _____, date of last period _____.
Men: prostate problems? _____
Do allergies or allergy medications affect your sexual activity (excessive dryness, impotency, etc.)? _____
- **Musculo-skeletal:** joint pains or swelling, "growing pains", cramps (at night with activity, other ____), bone pain, muscle pain, muscle tenderness, muscle weakness, neck pain, back pain, paralysis, polio, spina bifida, wear braces, crutches, wheelchair, broken bones, decreased bone density.
- **Skin:** cradle cap, sever dandruff, eczema (occasional, constant, mild, sever, limited area, all over), psoriasis, itch (mild, severe), itch without rash, hives (occasional, daily, seasonal), swelling (lips, hands, feet), recurrent blisters, sun sensitive, cold hands or feet, hot hands or feet, excessive sweating, body odor, fungus (skin, nails), easy bruising, dry skin, excessive hair loss, sever flushing (ears, cheeks).

MEDICAL HISTORY (continued)

PATIENT'S NAME: _____ **Date of Birth:** _____

SYMPTOMS (continued)

■ **Nervous System:** seizures, aggression (verbal, physical), impulsive, learning disabilities, high IQ, numbness or tingling (hands, feet, other _____), nightmares, difficulty getting to sleep, difficulty staying asleep, phobias, depression, heavy stress (work, home, school, marriage), headaches, migraines (hurt all over, one-sided, warning before pain starts, sinus). Do you have associated vomiting, sensitivity to light, weakness before headache starts, losing memory, foggy thinking), cerebral palsy, mentally challenged, autism, need special education, panic attacks, chronic fatigue, excessive irritability, frequent mood swings. Other: _____

MEDICATIONS

Please list ALL current medications including dosage and % of improvement of symptoms. (Use separate sheet if needed)

Medication and dosage	Improvement
_____	_____
_____	_____
_____	_____
_____	_____

Please list any previous medications taken and the reason you no longer use them.

Medication and dosage	Reason
_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

List any medical problems, and if deceased, list cause of death.

Father: Age _____ _____

Mother: Age _____ _____

Siblings: Age _____ Sex _____ _____

 Age _____ Sex _____ _____

 Age _____ Sex _____ _____

Children: Age _____ Sex _____ _____

 Age _____ Sex _____ _____

 Age _____ Sex _____ _____

MEDICAL HISTORY (continued)

PATIENT'S NAME: _____ **Date of Birth:** _____

FAMILY HISTORY (continued) Other family members: Aunts, Uncles, cousins, grandparents:

- Asthma/recurrent bronchitis _____ Nasal Allergy _____
- Sinus _____ Rashes/Hives _____
- Eczema _____ Psoriasis _____
- Cystic Fibrosis _____ Colitis _____
- Ulcers _____ Arthritis _____
- Indigestion/reflux _____ Tuberculosis _____
- Kidney problems _____ Chronic anemia _____
- Heart attacks _____ High Blood Pressure _____
- Strokes _____ Cancer (type) _____
- Diabetes _____ Thyroid problems _____
- Food allergies _____ Drug Allergies _____
- Seizures _____ Migraine headaches _____
- Immunity problems _____ Lupus _____
- Attention Deficit Disorder _____ Learning Disabilities _____

ENVIRONMENT

- Do you smoke now? Yes/No _____ Cigarette _____ Cigar _____ Pipe _____ Other _____
- Have you ever smoked? Yes/No _____ How long? _____ When did you stop? _____
- Does ANYONE that lives in your home smoke? Yes/No _____
- How old is your home? (house, apartment, condo, mobile home, duplex, house boat) _____
- Carpet: Old/New _____ Any special covers on pillow and mattress? _____
- Bedroom: Patient only OR Shared with someone else? _____
- Does your home sit on a slab _____ OR off the ground _____?
- Do air ducts go under the house? Yes/No _____ Can animals get under the house? Yes/No _____
- Does water stand under the house or drain slowly from the yard after a heavy rain? Yes/No _____
- Are there noticeable mold/mildew/musty odors inside or outside the home? Yes/No _____
- Is there heavy shade around or on the house? Yes/No _____
- Are there many leaves or mulches around the house or play area? Yes/No _____
- Has there ever been a flood or water leak inside the home? Yes/No _____
- Are you within ¼ mile of untreated water? (lake, creek, pond, river, ocean, intracoastal, swamp, marsh, etc.)? Yes/No _____

MEDICAL HISTORY (continued)

PATIENT'S NAME: _____ **Date of Birth:** _____

ENVIRONMENT (continued)

What trees and shrubs are within ¼ mile of your home? (oak, pine, maple, cedar, hickory, pecan, ash, sycamore, sweet gum, birch, beech, bayberry, magnolia eucalyptus, azalea, ligustrum/privet, pitisporum, holly, etc.)? _____

How often is the home dusted? _____ Is it hard to keep away? _____

How often is the home vacuumed? _____

Is road: Paved ___ Dirt ___ Both ___ Windows are open: always ___ mostly ___ seasonally ___ never ___

Air conditioning: Central ___ Window Unit ___ None ___ Is temperature inside: Even ___ Hot spots ___ Cold spots ___

Air conditioning filter is: throw away ___ cleanable ___ electrostatic ___ HEPA ___ Other _____

How often do you clean or replace the A/C filter? _____

Do you use a humidifier? Yes/No ___ Do you use a dehumidifier? Yes/No ___

Do you use additional air filters in your home? _____

If yes, what type _____ which room(s) _____

Heat is: Electric ___ Gas ___ Fuel Oil ___ Space Heater ___ Central Heat ___

Water is: city ___ well ___ bottled ___ filtered ___ reverse osmosis system ___ water softener ___

WORK

Indoors: small office, large room with partitions, excess dust, mold, strong smells, frequent travel (drive ___ fly ___)

Outdoors: chemicals, dust, paint, etc. _____

At work are your symptoms: better ___ worse ___ no different ___

How many days of work have you missed for allergy-related problems in the past 12 months?

HOBBIES

What types of hobbies do you have? _____

Do any of these affect your allergies? Yes/No ___ If yes, which hobbies and how do they affect you? _____

INSECTS

Reaction to insect stings is: (choose ONE)

- Small spot that clears in a few hours
- Small spot, grows over 6-12 hours to very itchy 25-50 cent size and lasts several days
- Delayed or immediate swelling covers entire hand, foot or face
- Itchy & hives all over body
- Coughing, wheezing, or very sleepy minutes to hours after the sting

MEDICAL HISTORY (continued)

PATIENT'S NAME: _____ **Date of Birth:** _____

SEASONS

Do you notice a seasonal pattern? (symptoms either only occur or are obviously worse certain times of year) Yes/No _____

If yes, please state either the symptoms or months that seem to be worse. _____

PETS

Do you have pets inside the home? Yes/No _____ If yes, list ALL pets and breeds if known, how long you have had them and if they are permitted in patient's bedroom. _____

Do you use any special litter for pets? Yes/No _____ If yes, what kind of litter? _____

DIET

Circle **ALL** food that you eat **3 times a week or more** on a regular basis.

Cheese, yogurt, ice cream, pudding, bread, rice, potato, pasta, cereal, eggs, banana, grapes, apples, oranges, canned fruits, beans, peas, carrots, corn, broccoli, cauliflower, salads, chocolate, chips, crackers, cookies, fish, shellfish, tea, 100% juice, fruit drinks, Gatorade, pizza, peanut butter, beef, chicken, pork, turkey, gravy, barbeque sauce, alcoholic beverages, artificial sweeteners, milk (how many oz a day _____) sodas/diet drinks (how many bottles/cans a day _____)

Any other food? _____

List any foods that you **react to** and the reaction you have to that food

Food _____ Reaction _____

Food _____ Reaction _____

List any foods that you crave

Have you ever done a food elimination diet? Yes/No ____ Did your symptoms improve or clear? _____

SUPPLEMENTS

Circle ALL food supplements that you take, list any you take but are not listed below

Calcium, magnesium, Echinacea, golden seal, allergy-fighters, L-glutamine, Evening primrose oil, chromium picolinate, vitamin E, vitamin C, vitamin B-12, B complex, St. John's wort, multivitamin, beta-carotene, acidophilus, any others:

MEDICAL HISTORY (continued)

PATIENT'S NAME: _____ **Date of Birth:** _____

How do the following exposures influence your symptoms?

	Never Notice	No Effect	Questionable	Definite	Dramatic		Never Notice	No Effect	Questionable	Definite	Dramatic
Cleaning/sweeping						Hair spray/air fresheners					
Turning on furnace or car A/C						Cooking odors					
Overstuffed/antique furniture						Gasoline/exhaust fumes					
Old books/magazines						Detergents/soaps					
High pollen count						Ammonia/floor cleaners					
Yard work/fresh cut grass						Furniture polish					
Moldy/musty areas						Varnish/lacquer/paint					
Farms/barns/hay						Photocopy/newspapers					
Breweries/dairies						Cleaning chemicals					
Attic/basements						Insecticides					
Summer/beach homes						Herbicides/mothballs					
Potted plants/fresh flowers						Rubber (gloves/balloons)					
Furs/fuzzy blankets						Gas/stove heat/floor furnace					
Dog/cat/horse/other animals						Nail polish/remover					
Zoo/pet store/circus						Grocery store					
Chicken/pigeons/other birds						Department store					
Feather pillows						Fabric store/particular fabric					
Upper respiratory infections						Steam bath/hot shower					
Emotional stress/anxiety						Direct draft					
Physical exertion						Cold temperature					
Laughing/crying						Hot temperature					
Menstrual period						Sudden temperature change					
Pregnancy						Windy day					
Tobacco smoke						Muggy day					
Smoke from other sources						High humidity					
Perfumes/deodorants						Low humidity					
After shave/colognes						Increased air pollution					

MEDICAL HISTORY (continued)

PATIENT'S NAME: _____ **Date of Birth:** _____

CHILDREN ONLY

Was the pregnancy for this child considered normal? _____

Was the child premature? _____

Delivered by c-section? Yes/No _____ Birth weight _____

Breast fed? _____ How long? _____ Formula (name all that were used) _____

Circle **ALL** symptoms that were experienced

Colic Excess gas Spitting Fussy Diarrhea Rash Projectile vomiting Cradle cap Thrush Recurrent/severe diaper rash

Circle **ALL** the vaccinations the child has had

DTAP Polio MMR Hib Hep Bvaricella/chicken pox

Were the reactions normal? Yes/No _____ If no, explain in detail. _____

At what age did the child accomplish the following: Sit _____ Crawl _____ Walk _____ Talk _____

Is there either a delay in speech or pronunciation problem? _____

Is the child getting speech therapy? _____

This child is in: Daycare _____ Private sitter/family sitter _____ School (public/private/home) _____

What grade in school? _____ Grades are: Average _____ Above average _____ Below average _____

How many hours per day of computer? _____ How many hours per day of television? _____

Does this child have problems: Staying in his/her seat _____ Completing assignments _____ Finishing work _____

