*** Please complete carefully and to the best of your knowledge – do not be concerned if you do not know the answer to all of the questions.***

Patient's Name: ______________________________ Date: ______________
(please print)
Patient's DOB: ________________

CONSENT TO OBTAIN EXTERNAL PRESCRIPTION HISTORY

I AUTHORIZE **Asthma & Allergy Physicians** to extract my external prescription history via the RX HUB service in their electronic medical records system. I understand that the prescription history from multiple other unaffiliated medical providers, insurance companies, and pharmacy benefit managers may be viewable by my providers and staff here, and it may include prescriptions back in time for several years. My signature certifies that I read and understood the scope of my consent and that I authorize the access.

Patient (or Guardian) Signature ______________________________ Date: ______________
(Please list any over-the-counter medications, vitamins and herbals below)

- -

IN ADDITION - Please list all current medications, herbals and vitamins:

Name/Strength/How Often	Name/Strength/How Often

Medication Allergies: **List:** **Reaction:**

______________________________ ______________________________

Surgical History:

Procedure(s)	Date	Procedure(s)	Date

Hospitalization History:

Cause:	Date	Cause:	Date

Patient's Name ______________________________

PAST MEDICAL HISTORY
(Please **CIRCLE** if diagnosed or Currently have these conditions:

CONSTITUTIONAL:
Cancer: Type ______________

ALLERGY/IMMUNOLOGIC:
Allergies – Environmental
Angioedema (swelling of skin)
Hives
Recurrent infections – or rashes
Eczema
Food allergy _______________
Reactions to stinging insects
Autoimmune disease _________

CARDIOVASCULAR:
Chest pain or discomfort
Irregular or fast heart beat
History of heart murmur
History of Rheumatic Fever
History of heart failure
Congenital heart disease
Heart attack
High blood pressure
High cholesterol level

ENDOCRINE:
Diabetes – Type I or Type II
Underactive thyroid
Overactive thyroid
Low blood sugar – Hypoglycemia

EYES:
Conjunctivitis – (pink eye)
Allergic – Bacterial
Glaucoma

GASTROINTESTINAL:
Celiac disease
GERD
Ulcers
Other food reactions __________

GENITOURINARY:
For females –
Pregnant or ? pregnant – Yes No

HEMATOLOGIC:
HIV/AIDS
Anemia
Hepatitis

HENT:
Headaches – Migraines
Otitis media – (ear infection)
Chronic sinusitis

MUSCULOSKELETAL:
Fibromyalgia
Arthritis – Osteo or Rheumatoid
Osteoporosis – Osteopenia

NEUROLOGICAL:
Seizures
Stroke – TIA

PSYCHIATRIC:
Depression
Anxiety
Bipolar Disorder

RESPIRATORY:
Bronchitis
Pneumonia
Asthma
Chronic cough
Shortness of breath
COPD – emphysema
Tuberculosis
Coughing up blood
Other unlisted medical conditions:
____
____
____

FAMILY HISTORY: Must be completed for Immediate Family (Please circle all that apply)
A=Alive D=Deceased, YOB=year of birth. (If not known, please enter their age)

(****CIRCLE**** any illnesses they have below – Please list up to 1 or 2 Siblings or Children – if None – leave blank)

Father	A or D	YOB _______	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Mother	A or D	YOB _______	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Sibling 1	A or D	YOB _______	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Sibling 2	A or D	YOB _______	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Child 1	A or D	YOB _______	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown
Child 2	A or D	YOB _______	or Age____	Diabetes	Hypertension	Heart Disease	Stroke	Mental Illness	Cancer	Unknown

Siblings	# of brothers _______	# of sisters _______	Healthy – Yes	No
Children	# of sons _______	# of daughters_______	Healthy – Yes	No

Asthma/Allergy Family History: Please list family member(s) and allergic conditions: ___________

____

____

Patient's Name ______________________________

SOCIAL HISTORY:

Smoking: Please circle if you are:

NEVER SMOKER current smoker former smoker vaping uses tobacco in other forms

Please circle form of tobacco: cigarette cigar pipe chewing tobacco snuff

Current/Past smoking history – please circle how many cigarettes you smoke – or did smoke per day:

1-9 cigarettes 10-19 cigarettes 20-39 cigarettes 40+ cigarettes per day chain smoker

If you stopped smoking - please answer the questions below:

How many years did you smoke ______________________________

At what age did you start smoking ___________ At what age did you stop smoking ___________

Are you currently: (Please circle one) exposed to second hand smoke not exposed to second hand smoke

WORK ENVIRONMENT:

Occupation: ____

ENVIRONMENTAL HISTORY: (Please circle all that apply)

Pillow Contents:	Cotton	Feather	Foam	Non-allergenic	Polyester	Tempurpedic	
Mattress Contents:	Air	Feather	Foam	Spring	Tempurpedic	Water	
Comforter Contents	Feather	Cotton	Polyester				
Dust Mite Covers:	Pillow	Mattress	None Used				
Flooring in Bedroom:	Carpet	Area Rug	Wall-to-wall	Hardwood	Linoleum	Tile	Vinyl
Flooring in Home:	Carpet	Area Rug	Wall-to-wall	Hardwood	Linoleum	Tile	Vinyl
Pets:	None	Cat	Dog	Bird	Fish	Gerbil	
	Guinea Pig	Hamster	Mouse	Rabbit	Other ___________		

Farm Animals: Please List: ____

Home Heated by:	Forced hot air by gas	Forced hot air by oil	Forced hot air by propane
	Forced hot water by gas	Forced hot water by oil	Forced hot water by propane
	Electric baseboard	Steam (radiator)	
	Coal stove	Pellet stove	Wood stove

IMMUNIZATIONS:

Have you had a flu shot in the last year? Yes _________ No _________

If yes please give date (or approximate date) of flu shot: ____________________

Have you had a pneumonia shot in the last 5 years? (Pneumovax/Prevnar) Yes _________ No _________

If yes please give date (or approximate date) of pneumonia shot: ____________________

Have you been hospitalized in the last year? Yes _________ No _________

If yes please give date (or approximate date) of discharge. ____________________