

PATIENT HISTORY

Georgia Medical Specialists, LLC

Instructions

Carefully complete in full. Accuracy and thoroughness are essential. Print all answers. Relate all answers to your own experiences, not to previous advice on skin tests. This form must be completed prior to seeing the physician. *All information will be considered confidential.*

Name _____ Street _____
City _____ State _____ Zip _____ Telephone _____
Age _____ Sex _____ Race _____ Occupation _____

Name of referring physician _____ Street _____
City _____ State _____ Zip _____ Telephone _____

State problems you wish to discuss: _____

When did it begin? _____ (Year) How often does it occur? _____ (# of times per day, week, etc.)

Worse at night or day? _____ How long does it last? _____ (Hours, days, etc.)

Check months most severe:

- | | | | |
|-------------------------------------|--------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> All months | | | |
| <input type="checkbox"/> January | <input type="checkbox"/> April | <input type="checkbox"/> July | <input type="checkbox"/> October |
| <input type="checkbox"/> February | <input type="checkbox"/> May | <input type="checkbox"/> August | <input type="checkbox"/> November |
| <input type="checkbox"/> March | <input type="checkbox"/> June | <input type="checkbox"/> September | <input type="checkbox"/> December |

What do you think makes it better? _____

What do you think makes it worse? _____

What do you think causes the problem? _____

Check items that affect your symptoms

- | | | | | |
|------------|--|---|--|--|
| Irritants | <input type="checkbox"/> Cleanser | <input type="checkbox"/> Detergent | <input type="checkbox"/> Cooking odor | <input type="checkbox"/> Perfume |
| | <input type="checkbox"/> Powder | <input type="checkbox"/> Tobacco smoke | <input type="checkbox"/> Other smoke, specify: _____ | |
| | <input type="checkbox"/> Moth Balls | <input type="checkbox"/> Motor Fumes | <input type="checkbox"/> Paint lacquer | <input type="checkbox"/> Wax |
| | <input type="checkbox"/> Glue | <input type="checkbox"/> Insect spray | <input type="checkbox"/> Fertilizers | <input type="checkbox"/> Ammonia |
| | <input type="checkbox"/> Room deodorants | <input type="checkbox"/> Chemical fumes | <input type="checkbox"/> Clorox | <input type="checkbox"/> Other: _____ |
| Toiletries | <input type="checkbox"/> Soap | <input type="checkbox"/> Shampoo | <input type="checkbox"/> Shaving cream | <input type="checkbox"/> Aftershave |
| | <input type="checkbox"/> Spray deodorant | <input type="checkbox"/> Hair spray | <input type="checkbox"/> Hair tonic | <input type="checkbox"/> Hair dye |
| | <input type="checkbox"/> Hand cream | <input type="checkbox"/> Make-up | <input type="checkbox"/> Toothpaste | <input type="checkbox"/> Denture cream |
| | <input type="checkbox"/> Mouthwash | <input type="checkbox"/> Nail Polish | <input type="checkbox"/> Other: _____ | |
| | | | | |

- Foods
- | | | | |
|---------------------------------------|---------------------------------------|---|--|
| <input type="checkbox"/> Milk | <input type="checkbox"/> Cheese | <input type="checkbox"/> Eggs | <input type="checkbox"/> Fish |
| <input type="checkbox"/> Shellfish | <input type="checkbox"/> Nuts | <input type="checkbox"/> Chocolate | <input type="checkbox"/> Alcohol |
| <input type="checkbox"/> Wine | <input type="checkbox"/> Beer | <input type="checkbox"/> Juices | <input type="checkbox"/> Spices |
| <input type="checkbox"/> Vegetables | <input type="checkbox"/> Strawberries | <input type="checkbox"/> Wheat products | <input type="checkbox"/> Very cold liquids |
| <input type="checkbox"/> Other: _____ | | | |

- Pets
- Which of these do you have as pets:
- | | | | |
|----------------------------------|---------------------------------|--------------------------------|--------------------------------|
| <input type="checkbox"/> Dog | <input type="checkbox"/> Cat | <input type="checkbox"/> Birds | <input type="checkbox"/> Horse |
| <input type="checkbox"/> Hamster | <input type="checkbox"/> Rabbit | <input type="checkbox"/> Other | _____ |
- Is your condition worse around pets? Yes No
- Specify: _____

- Drugs
- | | | |
|---------------------------------------|--------------------------------|---|
| <input type="checkbox"/> Penicillin | <input type="checkbox"/> Sulfa | <input type="checkbox"/> Over-the-counter drugs, specify: _____ |
| <input type="checkbox"/> Other: _____ | | |

- Weather
- | | | | |
|--|-------------------------------|-----------------------------------|---|
| <input type="checkbox"/> Hot | <input type="checkbox"/> Cold | <input type="checkbox"/> Humid | <input type="checkbox"/> Damp |
| <input type="checkbox"/> Pollution | <input type="checkbox"/> Smog | <input type="checkbox"/> Sunlight | <input type="checkbox"/> Air-conditioning |
| <input type="checkbox"/> Change in temperature | | | |

- New (unwashed) Clothing
- | | | | |
|--------------------------------|--|---|--------------------------------|
| <input type="checkbox"/> Wool | <input type="checkbox"/> Silk | <input type="checkbox"/> Sweater | <input type="checkbox"/> Coat |
| <input type="checkbox"/> Shoes | <input type="checkbox"/> Dry-cleaned clothes | <input type="checkbox"/> Starched clothes | <input type="checkbox"/> _____ |
| Other: _____ | | | |

- Contactants
- | | | | |
|---------------------------------------|--|--|--|
| <input type="checkbox"/> Poison ivy | <input type="checkbox"/> Cut grass | <input type="checkbox"/> Cut flowers | <input type="checkbox"/> Household plants |
| <input type="checkbox"/> Hay | <input type="checkbox"/> Christmas trees | <input type="checkbox"/> Plastic | <input type="checkbox"/> Rubber |
| <input type="checkbox"/> Fiberglass | <input type="checkbox"/> Dust | <input type="checkbox"/> Wool blankets | <input type="checkbox"/> Feather pillows |
| <input type="checkbox"/> Mattress | <input type="checkbox"/> Furs | <input type="checkbox"/> Rugs | <input type="checkbox"/> Overstuffed furniture |
| <input type="checkbox"/> Rug pads | <input type="checkbox"/> Stuffed toys | <input type="checkbox"/> Jewelry | <input type="checkbox"/> Shoe polish |
| <input type="checkbox"/> Other: _____ | | | |

Check Symptoms experienced

- General
- | | | | |
|---|------------------------------------|---------------------------------------|--|
| <input type="checkbox"/> Nervousness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting | <input type="checkbox"/> Sinus trouble |
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Other: _____ | |

- Headache
- Where? (front, back, right, left) _____
- | | | | |
|--|--------------------------------------|--|---|
| <input type="checkbox"/> Aching | <input type="checkbox"/> Throbbing | <input type="checkbox"/> Day | <input type="checkbox"/> Night |
| <input type="checkbox"/> With vomiting | <input type="checkbox"/> Stuffy nose | <input type="checkbox"/> Sharp | <input type="checkbox"/> Dull |
| <input type="checkbox"/> Spots before eyes | | <input type="checkbox"/> Better with sleep | <input type="checkbox"/> Worse with tension |
- Cause :
- | | | | |
|-----------------------------------|---------------------------------------|--------------------------------|----------------------------------|
| <input type="checkbox"/> Migraine | <input type="checkbox"/> Food | <input type="checkbox"/> Sinus | <input type="checkbox"/> Tension |
| <input type="checkbox"/> Drug | <input type="checkbox"/> Other: _____ | | |

- Skin
- | | | | |
|----------------------------------|---------------------------------------|----------------------------------|--|
| <input type="checkbox"/> Rash | <input type="checkbox"/> Hives | <input type="checkbox"/> Eczema | <input type="checkbox"/> Blisters |
| <input type="checkbox"/> Itching | <input type="checkbox"/> Swelling | <input type="checkbox"/> Burning | <input type="checkbox"/> Stinging |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Perspiration | | <input type="checkbox"/> Athletes foot |
- Where: _____ Worse after eating? Yes No

- Eyes
- | | | | |
|----------------------------------|------------------------------------|------------------------------------|-------------------------------------|
| <input type="checkbox"/> Tearing | <input type="checkbox"/> Burning | <input type="checkbox"/> Itching | <input type="checkbox"/> Pain |
| <input type="checkbox"/> Redness | <input type="checkbox"/> Discharge | <input type="checkbox"/> Puffiness | <input type="checkbox"/> Infections |

	<input type="checkbox"/> Blurring of vision	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Other : _____	
Ears	<input type="checkbox"/> Pressure <input type="checkbox"/> Infection	<input type="checkbox"/> Itchiness <input type="checkbox"/> Deafness	<input type="checkbox"/> Drainage <input type="checkbox"/> Swelling	<input type="checkbox"/> Bleeding <input type="checkbox"/> Other: _____
Nose	<input type="checkbox"/> Sneezing <input type="checkbox"/> Itching <input type="checkbox"/> Polyps <input type="checkbox"/> Previous Surgery	<input type="checkbox"/> Stuffiness <input type="checkbox"/> Cloudy discharge <input type="checkbox"/> Postnasal drip <input type="checkbox"/> Change in voice	<input type="checkbox"/> Sniffles <input type="checkbox"/> Snoring <input type="checkbox"/> Bleeding <input type="checkbox"/> Other: _____	<input type="checkbox"/> Clean running discharge <input type="checkbox"/> Difficulty in smelling <input type="checkbox"/> Broken nose
Tongue	<input type="checkbox"/> Swollen <input type="checkbox"/> Difficulty in testing	<input type="checkbox"/> Sore <input type="checkbox"/> Other: _____	<input type="checkbox"/> Itching	<input type="checkbox"/> Coated
Mouth	<input type="checkbox"/> Itching of roof <input type="checkbox"/> Bad breathe <input type="checkbox"/> Mouth breathing	<input type="checkbox"/> Repeated tonsillitis <input type="checkbox"/> Swollen lip <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tonsils removed <input type="checkbox"/> Trouble swallowing	<input type="checkbox"/> Morning sore throats <input type="checkbox"/> Frequent throat clearing
Mucus	<input type="checkbox"/> Thick <input type="checkbox"/> Green	<input type="checkbox"/> Thin <input type="checkbox"/> Brown	<input type="checkbox"/> Clear <input type="checkbox"/> Bloody	<input type="checkbox"/> Yellow
	Amount per day (teaspoon, tablespoon, 1/2 cup) _____			
	Source of mucus (nose, lungs, throat) _____			
Chest	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Cough <input type="checkbox"/> Emphysema <input type="checkbox"/> Bronchitis <input type="checkbox"/> Other: _____	<input type="checkbox"/> Wheeze <input type="checkbox"/> Cough with wheeze <input type="checkbox"/> Heart trouble <input type="checkbox"/> Pneumonia	<input type="checkbox"/> Pain <input type="checkbox"/> Difficulty in walking <input type="checkbox"/> High blood pressure <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Tightness <input type="checkbox"/> Difficulty in working <input type="checkbox"/> Difficulty in sleeping <input type="checkbox"/> Cancer
Stomach	<input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Soiling: Worse after eating what foods? <input type="checkbox"/> Other: _____	<input type="checkbox"/> Gas <input type="checkbox"/> Mucus in stool	<input type="checkbox"/> Cramps <input type="checkbox"/> Blood in Stool	<input type="checkbox"/> Belching <input type="checkbox"/> Foul-smelling stool
Joints	<input type="checkbox"/> Pain	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other: _____
Menses	<input type="checkbox"/> Regular <input type="checkbox"/> Cramps	<input type="checkbox"/> Irregular <input type="checkbox"/> Infections	<input type="checkbox"/> Discharge <input type="checkbox"/> Last period (date) _____ No	<input type="checkbox"/> Itch Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No
	Are you pregnant now? <input type="checkbox"/> Yes <input type="checkbox"/> No	Taking birth control pills: <input type="checkbox"/> Yes <input type="checkbox"/> No		
Kidneys	<input type="checkbox"/> Pain <input type="checkbox"/> Itching	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Chills	<input type="checkbox"/> Bladder infection <input type="checkbox"/> Fever	<input type="checkbox"/> Recurrent infection <input type="checkbox"/> Other: _____

Check pertinent items and fill in the blanks

Where do you live?	<input type="checkbox"/> Room <input type="checkbox"/> Mobile Home	<input type="checkbox"/> Apartment <input type="checkbox"/> Age of House _____	<input type="checkbox"/> Brick house	<input type="checkbox"/> Wood-frame house
Location	<input type="checkbox"/> City	<input type="checkbox"/> Suburb	<input type="checkbox"/> Country	<input type="checkbox"/> Farm

- Seashore
- Desert
- Mountains
- Near factory
- Near bakery
- Near grain storage
- Near swamp
- Near poultry yard
- Near barn
- Other: _____

- Problem worse in
- Bedroom
 - Living room
 - Kitchen
 - Basement
 - Attic
 - Garage
 - Indoors
 - Outdoors
 - Other: _____

- Type of heating
- Forced air
 - Radiator
 - Electric
 - Heat pump
 - Filtered air
 - Other: _____

- Problem worsens when
- At home
 - At work
 - In car
 - In boat
 - Exercising
 - Hair salon
 - At school
 - Driving in traffic
 - Sweeping
 - House cleaning
 - Making beds
 - Around open windows
 - Around Humidifiers
 - Around vaporizer
 - Around fans
 - Around heating
 - On windy days
 - Swimming in chlorinated water
 - Taking hot or cold baths
 - In musty places
 - Other: _____

- Insect bites or stings
- Large swelling
 - Weakness
 - Sweating
 - Shortness of breath
 - Stuffy nose
 - Wheezing
 - Other : _____

- Smoking habits
- Cigarettes
 - Cigars
 - Pipes
- Number per day: _____ How long? (years) _____

Medications (please include dosage) _____
 Now used _____

Place age of family members having any of the following conditions in the appropriate space:

	Father	Mother	Brother	Sisters	Children	Other
Migraine						
Hives						
Emphysema						
Asthma						
Cystic Fibrosis						
Eczema						
Hay Fever						
Tuberculosis						
Thyroid Disease						
Glaucoma						

Unusual activities engaged in just prior to onset of symptoms

Unusual food or drink ingested just prior to onset symptoms

New environmental factors at home or at work

List any medical condition(s) for which you have been treated

List any surgery you have had

List any other conditions for which you are currently being evaluated or treated:

Physician's analysis
