Allergy & Asthma Specialists of Michigan

Angela M. Iacobelli, M.D.
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www.aasmich.com

MEDICAL HISTORY FORM

NAME:_____ DATE OF BIRTH: _____

Past Medical History (Circle any of the following that you currently have or have been treated for in the past):

ADD/ADHD	COPD	Liver Disease
Alcoholism	Depression	Lupus
Allergies (Environmental)	Diabetes	Migraines
Anemia	Diverticulitis	Nasal Polyps
Anxiety	Eczema	Osteoporosis
Arthritis	Food Allergies	Pneumonia
Asthma	GI problems	Prostate Disorder
Autism	GERDs/Reflux	Psoriasis
Autoimmune Disease	Gout	Rashes
Bee Sting Allergy	Heart Palpitations/ Irregular Rhythm	Seizures
Bladder Problems	Heart Disease	Sinus problems
Bipolar Disorder	Heart Murmur	Sleep Apnea
Cancer	Hepatitis	Stroke
Celiac Disease	High Blood Pressure	Thyroid problems
Cholesterol Problems	Immune Deficiency	Ulcerative Colitis
Chronic Cough	Irritable Bowel Syndrome	Uterine/Menstrual problems
Crohn's Disease	Kidney Disease	
Congestive Heart Failure	Kidney Stones	

OTHER:_____

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Past Surgical History (Circle any of the following surgeries that you have previously had performed in the past):

Adenoidectomy Appendectomy Arthroscopic Joint Surgery Back Surgery Bariatric/Weight loss surgery Bladder Suspension Breast (lumpectomy/mastectomy) Gallbladder Removal	Cataract surgery C section Deviated septum repair Ear tubes Hernia repair Heart Bypass (CABG) Heart Stents Hysterectomy	Joint replacement: Shoulder (R or L) Knee (R or L) Hip (R or L) Ovarian Surgery Pacemaker Prostate Surgery Sinus Surgery Tonsillectomy Thyroid surgery	Other:_____ _____ _____ _____ _____ _____

Family History (Please indicate any family history of the following):

	Grandparent	Mother	Father	Sibling	Children
Healthy and no problems					
Unknown					
Allergies					
Asthma					
Autoimmune problems					
Eczema					
Food Allergies					
Hives					
Hypertension (high blood pressure)					
Hyperlipidemia (high cholesterol)					
Immune Deficiency					
Recurrent infections					
Psychiatric Disorder					

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Social History (Circle the following pertinent items and fill in information where indicated if applicable):

Marital Status:	**Single** **Married** **Divorced/Separated** **Widow(er)**
Smoking Status:	**Never Smoked** **Former Smoker** quit date _____; daily average _____; # of years _____ **Current Smoker** daily average_____; # of years _____) **Second-hand Smoke Exposure:** none parents spouse/partner caretaker other
Occupation:	
Hobbies:	
Housing:	**Location:** city suburban rural farm lake **I live in a:** house apartment/condo mobile/manufactured home **I have lived here for:** _____(# months/years) **Age of home:** _____ **Foundation:** basement crawlspace slab **Air Conditioning:** central none window units **Heating:** natural gas forced air furnace radiant heat wood stove **Air Cleaners:** none free standing central furnace air cleaner **Bedroom:** wood floor wall to wall carpet area rug tile linoleum **Bed:** standard mattress water bed feather pillow down comforter
Pets:	**Do you have pets?** Yes No **If yes, how many of each type of pet do you own?** Dog(s)___ Cat(s)___ Bird(s)___ Guinea pig(s)___ Hamster(s)___ Horse(s)___ Rabbit(s)___ **Are the pets allowed in the bedrooms?** Yes No

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Pediatric Patients Only (Circle the following items and fill in information if indicated)

Child lives with:	Both parents Parents are divorced Guardian(s)
Schooling:	**Grade Level:** _____
Does the child attend daycare:	Yes No _____ **If yes:** full-time part-time
Does child have siblings:	Yes No _____ If yes, how many: _____
Birth/Developmental history:	**Child was born:** Premature Full-term **Child had prolonged hospitalization:** Yes No **Breast fed:** Yes (# months _____) No **Feeding difficulties:** Yes No **Recurrent infections:** Yes No **LATE on immunizations:** Yes No **ABNORMAL growth/development:** Yes No

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Review of Systems

NAME:_____ **DATE OF BIRTH:** _____

General	Nose	Cardiovascular	Genitourinary	Neurologic
no problem weight gain fevers chills sweats poor appetite fatigue weight loss	no problems nasal congestion loss of sense of smell runny nose post nasal drip nose bleeds itching sneezing sinus pain/pressure	no problems chest pains irregular heart beat/palpitation shortness of breath when lying down flat	no problems frequency of urination pain/burning with urination incontinence blood in urine difficulty emptying bladder kidney stones abnormal uterine bleeding irregular menstrual cycle prostate problems	no problems headaches weakness numbness dizziness seizures tremors
Eyes	**Mouth/Throat**	**Respiratory**	**Musculoskeletal**	**Mental Health**
no problems discharge dry eye pain itchy red swollen tearing vision loss	no problems hoarseness difficulty swallowing sore throat lip swelling throat clearing itching of the roof of the mouth/throat loss of sense of taste	no problems cough chest tightness coughing blood daytime sleepiness shortness of breath snoring wheezing difficulty with exercise	no problems back pain joint pain joint swelling leg swelling stiffness	no problems addiction anxiety/panic attacks depression hyperactivity eating disorders autism
Ears	**Blood/Lymph/ Endocrine**	**Gastrointestinal**	**Skin**	**Allergic/Immune**
no problem ear pain ear pressure hearing loss fullness itching popping infections ringing vertigo	no problems swollen lymph nodes blood clots bleeding tendencies blood transfusion heat intolerance cold intolerance excessive thirst	no problems recurrent bloating heartburn nausea vomiting diarrhea abdominal pain constipation bloody stool jaundice	no problems eczema hives itching swelling rashes	no problems recurring infections environmental allergies seasonal allergies latex allergy food allergy drug reaction bee sting allergy

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MEDICATION FORM

NAME:_____ **DATE OF BIRTH:** _____

Current Medications & Supplements

Medication Name	Milligrams	Times per Day	Taking this for what Diagnosis?

Allergies to Medications

Name of Medication	Reaction (hives, throat swelling, other)

☐ **NO KNOWN DRUG ALLERGIES**

Preferred Local Pharmacy	Mail Order Pharmacy
Name:	Name:
Street Address:	Street Address:
City:	City, State, Zip:
Telephone #:	Telephone #:
Fax #:	Fax #:

When was your last flu shot? _____
When was your last pneumonia shot? _____