Center for Minimally Invasive Surgery

Name:________________________ **DOB:**____/____/_____ **Gender:**__________ **PCP:**______________

Main reason for visit:__________________________ **Who referred you to our clinic:**__________________
If referred, please ensure the **most recent clinic note and referral form** has been sent prior to your visit.

PAST MEDICAL HISTORY: (Circle if **you** have any of the following or have had in the past).

Anxiety
Arthritis
Autoimmune Disease:___________
Thyroid disease
Celiac Disease
Cataracts
High Cholesterol
Kidney Disease
COPD
Depression
Diabetes
GERD/Reflux
Heart Disease
Glaucoma
Hypertension
Cancer:(type)____
Liver Disease
Migraines
Osteoporosis
Sleep Apnea
Congestive heart failure
Stroke
Other:____________________

SURGICAL HISTORY: (Circle if **you** have had surgeries in the past and provide dates/details).

Tonsils/Adenoids____________________________ Ear Tubes______________________________

Sinus Surgery_______________________________ Other:________________________________

FAMILY HISTORY: (please check appropriate box below; if other please write in relative)

Disease	Mom	Dad	Other	Disease	Mom	Dad	Other
Allergic rhinitis				Diabetes			
Asthma				Heart Disease			
Hives/Angioedema				Glaucoma			
Food allergy				Thyroid Disease			
Stinging insect allergy				Hypertension			
Atopic dermatitis/ Eczema				Cancer (type):___________			
Recurrent infections/ Immunodeficiency				Autoimmune Disease (type):____________			

Family history of any other condition:____

MEDICATIONS: (Fill in the information in table below)

Drug name and strength	How often	Drug name and strength	How often

IMMUNIZATION HISTORY:

Childhood immunization up to date: **Y** **N** Last flu shot:_______________
Have you received the Shingles vaccine: **Y** **N**
Last pneumonia vaccine if known (Pneumovax, Prevnar, etc.):________________

SOCIAL HISTORY:

Smoking/tobacco use: **Y** **N** Quit (if quit, how many packs/day:______ how many years: ________)
Type:__________________ Frequency:______________________
If you don't smoke, are there any smokers in the home? **Y** **N**
If yes, do they smoke: Outdoors Indoors Bedroom
Alcohol use: **Y** **N** Quit (if quit, how many years did you drink for ___________)
Type:__________________ Frequency:______________________
Recreational drugs: **Y** **N** (if yes, type:______________ and frequency of use:_____________________)
Occupation:____________________ Status: Employed Unemployed Retired
Hobbies:_______________________

ALLERGY SURVEY (Circle or fill in answer)**:**

Do you live in a: House Condo Apartment Mobile Home Other_____________
Lived there for how long:______________________ Age of residence:_____________years
Type of heating: Forced Air Baseboard Hot Water Wood Burning Steam Oil
Type of cooling: Central Air Window Unit None
Basement: **Y** **N** Finished Unfinished
Air Purifier: None Central Room unit (location_____________)
Humidifier: None Room unit (location______________)
Dehumidifier: None Room unit (location______________)
Any recent water damage: **Y** **N** Any damp/moldy areas: **Y** **N**
Is there carpeting in the home: **Y** **N** location(s)_______________________________

Bedroom flooring: Carpet (wall to wall) Tile Hardwood Laminate Area rug(s)
Bedroom contents: Blinds Bookshelves Drapes Plants Stuffed animals
Type of Mattress: Feather Synthetic Water Air. Other:_______________ Age:_______________
Type of pillow(s): Feather Cotton Foam Other:______________ Age:_________________
Dust mite covers: Mattress Pillows None
How often are sheets/bed covers washed:_____________________ Water used: Hot Cold Warm

Do you have any pets at home (if yes please provide details below): **Y** **N**
Cats How many: _____ How long: __________ Enter bedroom: **Y** **N** Cause symptoms: **Y** **N**
Dogs How many: _____ How long: __________ Enter bedroom: **Y** **N** Cause symptoms: **Y** **N**
Birds How many: _____ How long: __________ In the bedroom: **Y** **N** Cause symptoms: **Y** **N**
Rabbit How many: _____ How long: __________ Enter bedroom: **Y** **N** Cause symptoms: **Y** **N**
Other ________________ How long: __________ Enter bedroom: **Y** **N** Cause symptoms: **Y** **N**

Have you had previous allergy testing? **Y** **N** If yes, when:________clinic/doctor:____________________
Was this a Skin test: **Y** **N** Blood test: **Y** **N** test results:_____________________________________
Have you ever had a skin biopsy: **Y** **N** results:_________________________________

Please complete the following questionnaires *if you have a history* of the disease/symptoms. Feel free to skip and leave blank conditions that are non-applicable.

ALLERGIC RHINITIS (HAY FEVER/NASAL ALLERGIES) QUESTIONS: Y N

Symptoms are worse during which season: Spring Summer Fall Winter Year-round
If year-round, are symptoms worse during any time of year: **Y N** If yes, when:____________________
Does exposure to any of the following worsen your symptoms: Grass Trees Weeds Molds Dust Cats Dogs Other animals __________ Tobacco smoke Temp changes Perfumes Chemicals Odors Cold air Feathers Pillows Laughter Medications Exercise Spicy foods Other trigger:____________

Have you received sublingual immunotherapy (*allergy drops*)? **Y N** If yes, where:_________________
Have you been on *allergy shots* before: **Y N** If yes, where did you receive shots:__________________
For how long where you on them:____________ Why did you stop allergy shots:___________________
Did you have any systemic reactions to your shots: **Y N** If yes, please explain: ___________________
____

ASTHMA/RESPIRATORY QUESTIONS: Y N

Have you been formally diagnosed with asthma: **Y N** If yes, when were you diagnosed:___________
What age did you first start to have breathing problems: ________
What are your main asthma triggers:____
____
Have you been admitted to the hospital for asthma: **Y N** If yes, how many times:_________
Last asthma admission date/location:____
Have you ever been in the ICU for asthma: **Y N** Intubated/Ventilator for asthma: **Y N**
ED/Urgent care visits in the last 12 months for asthma/respiratory symptoms: **0 1 2 3 4+**
Number of oral or injectable (IM, IV) steroids in the last 12 months for asthma: **0 1 2 3 4+**

Do you have colds that “go to your chest” and take more than 10 days to get over? **Y N**
Have you ever had pneumonia: **Y N** If yes, how many times:_____________ Last time:____________
Have you ever had a chest CT scan: **Y N** If yes, when:__________ results:__________________
When was your last pulmonary function test/spirometry:____________ results:________________
Asthma/breathing problems with breathing during exercise: **Y N**
Asthma/breathing problems wake up you up at night: **Y N**
Have medications like aspirin, ibuprofen, naproxen, etc. made your asthma worse: **Y N**
What medications have you been on for asthma:____
Have you received a biologic (injection) for asthma: **Y N** If yes, which one(s):_____________________

CHRONIC SINUSITIS QUESTIONS: Y N

Prior sinus imaging (CT-scan)? If yes, when:__________ results:________________________________
How many separate courses of antibiotics for sinus infections in the last 12 months:___________
Which one(s):________________________________ Do they give relief when you receive them: **Y N**
Have you been diagnosed with nasal polyps: **Y N**
If you have not had sinus surgery, has sinus surgery been recommended: **Y N**
Have you received a biologic (injection) for nasal polpys: **Y N** If yes, which one(s):_________________

ATOPIC DERMATITIS/ECZEMA: Y N

Have you been formally diagnosed with atopic dermatitis: **Y N**
Diagnosed as an: Infant Child Teenager Adult
How frequently do you bathe_______________ for how many minutes ____________
Current brand of Soap_____________ Shampoo____________ Moisturizer_______________
Laundry detergent______________ Fabric softener__________________
What are the triggers for your eczema:____
____
Have you received oral or injectable steroids for your eczema: **Y N** If yes, last time:___________
Have you received oral or injectable antibiotics for your eczema: **Y N** If yes, last time:___________
Have you received a biologic (injection) for eczema: **Y N** If yes, which one(s):_______________________

FOOD ALLERGY: Y N

Have you been tested for food allergy: **Y N** If yes, was this test: Skin Blood Other:____________
When:__________ Results of testing:____
Have you been prescribed an epinephrine injector (EpiPen, AuviQ, etc) for food allergy: **Y N**
Have you ever had to use this device: **Y N** If yes, how many times:________ Last use:_________
Have you ever had an oral food challenge in a clinic: **Y N** If yes, provide details:_____________________
List all foods/drinks that you believe have caused an allergic reaction:
____
____

HIVES: Y N

How long have you had hives:_____________ Do you also have angioedema(swelling): **Y N**
Where on your body do you get hives:_______________________ Angioedema:_______________________
How long do individual lesions last before they clear:____________ Do they leave behind discoloration or bruising:_________ Are lesions itchy: **Y N** Painful: **Y N** Have you seen a dermatologist for this: **Y N**
What's the longest you've gone (days, weeks, months) without hives:_________________
Circle the following that make you worse: NSAIDs (aspirin, ibuprofen, etc.) Heat Cold Sun Water Skin pressure Exercise Sweating Stress Anxiety Infections Alcohol Hormones Foods____________
What have you taken for your hives/angioedema:____

DRUG ALLERGY: Y N

If yes, please list the medication and the reaction details below:
____
____
____
____

CONTACT DERMATITIS: Y N

Have you had patch testing in the past: **Y N** If yes, when and where was testing:____________________
Results of testing:____

INSECT ALLERGY: Y N

If you have had a reaction to an insect sting (bee, wasp, hornet, yellow jacket, fire ant), please describe:

Have you ever had venom allergy testing: **Y N** Venom immunotherapy (shots): **Y N** If yes, when were you on venom shots:____________________ who/where was your allergist:____________________
Have you been prescribed an epinephrine injector (EpiPen, AuviQ, etc) for stinging insect allergy: **Y N**
Have you ever had to use this device: **Y N** If yes, how many times:_______ Last use:________

LATEX ALLERGY: Y N

Do you have problems with rubber (latex) gloves, balloons, condoms, rubber bands or other rubber products/pacifier: **Y N** If yes, please describe:____
____

CONTRAST ALLERGY: Y N

If you have had a reaction to contrast media, please describe:___________________________________
____

ANAPHYLAXIS (SYSTEMIC ALLERGIC REACTION): Y N

If you have had anaphylaxis and it *was not addressed above*, please provide details:_________________
____
Have you been given an epinephrine injector (EpiPen, AuviQ, etc) for this: **Y N** Have you ever had to use this device: **Y N** If yes, how many times:_______ Last use:________

RECURRENT INFECTIONS/IMMUNODEFICIENCY: Y N

If you have had a history of recurrent infections or immunodeficiency, please describe:______________
____
Have you had formal immune testing: **Y N** If yes, results:_____________ Have you been on: IVIG SCIG

PEDIATRIC HISTORY (FOR CHILDREN ONLY): (please circle and fill in answers below)

Child was born: Full term Premature:______ weeks
Any hospitalizations as an infant: **Y N** If yes, provide details:___________________________________
Bottle fed or breast-fed? If breast fed, for how many weeks:_______
Any feeding difficulties: **Y N** If yes, provide details:_____________________________________
Recurrent infections: **Y N** If yes, provide details:_____________________________________
Sinusitis/URIs/colds go "to the chest" and take more than 10 days to clear: **Y N**
Child attends daycare: **Y N** Full time Part time Child attends school: **Y N** Grade________
Who does the child live with at home:____
Does the child have siblings: **Y N** If yes, how many:___________________
Do siblings have allergic diseases: **Y N** If yes, provide details:___________________________________
Any prior ED visits: **Y N** When:_________ where _________for what:_______________
Any prior hospitalizations: **Y N** When:_________ where _________for what:_______________
Childhood immunizations up do date: **Y N**

REVIEW OF SYSTEMS: (For each system circle if you are experiencing or if you have ever had. If system is negative then circle Negative and move to the next system)

GENERAL: Negative fevers chills night sweats weight gain weight loss change in appetite

EYES: Negative itchy watery dry discharge red eyelid swelling blurry vision

EARS: Negative hearing loss ringing recurrent ear infections drainage fullness/blockage ear itching

NOSE/SINUS: Negative congestion/stuffy nasal blockage runny nose sneezing itchy nose bleeding loss of smell postnasal drip snoring sinus pain sinus pressure recurrent sinus infections

MOUTH/THROAT: Negative mouth sores tongue swelling lip swelling decreased taste itchy throat hoarseness sore throats trouble swallowing painful swallowing throat clearing

RESPIRATORY: Negative cough sputum production wheezing chest tightness shortness of breath

CARDIOVASCULAR: Negative chest pain leg swelling palpitations

ABDOMINAL: Negative nausea vomiting diarrhea heartburn/reflux gas bloating pain discomfort bloody stools change in bowel habits

GENITOURINARY: Negative blood in urine frequency pain on urination frequent infections

MUSCULOSKELETAL: Negative joint pain joint swelling joint stiffness back pain muscle pain

SKIN: Negative hives itching swelling lesions rash dryness flushing

HEME: Negative easy bleeding easy bruising clotting disorders anemia

ENDOCRINE: Negative cold intolerance heat intolerance thyroid problems

NEURO: Negative headaches fainting paralysis seizures tingling numbness tremors

PSYCH: Negative anxiety depression stress nervousness panic attacks

Please let us know if there are any other important things we should know about your health history that was not mentioned above:____
____
____
____