Allergy, Asthma, Immunology & Rheumatology Institute

Kristin L. Bussey-Smith, MD

Name	Date of birth	Date

Do you have any of the following medical problems? Circle ALL that apply.
If you have NO medical problems or history of medical problems, please circle "I have no medical problems" at the bottom of the page.

Asthma	Environmental allergies
Food allergies	Pneumonia
Bronchitis	RSV
Alpha-1 anti-trypsin deficiency	Immunodeficiency
Recurrent infections	Eczema
Skin disease	Arthritis
Joint injury	Autoimmune disease
Lupus (SLE)	Sjogren's syndrome
Sarcoidosis	Fibromyalgia
Tuberculosis	Hepatitis C
Hepatitis B	Hypothyroidism (low thyroid)
Diabetes	Kidney disease
High Cholesterol	Heart Disease
High Blood Pressure	Reflux (GERD)
History of Stroke	Migraine headaches
Seizures	Cancer- if yes, what type?_____

Other Medical Problem(s): _____

I have no known medical problems.

The Medical Park at Stone Oak | 19260 Stone Oak Parkway | Suite 101 | San Antonio, TX 78258
Phone: 210-495-4335 | Fax: 210-615-3701 | Web: www.aairmd.com

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Name _____ **Date of birth** _____ **Date** _____

Have you had any surgeries? Please list the date and surgery.
Example: December 2001: Hysterectomy (uterus removal).

	Date of Surgery	Surgery Performed
1)		
2)		
3)		
4)		
5)		
6)		
7)		
8)		
9)		
10)		

Do you have any allergies to medications? YES NO

	Medication	Reaction (hives, tongue swelling, shortness of breath, etc)
1)		
2)		
3)		
4)		
5)		

Do you have any food allergies? YES NO

	Food	Reaction (hives, tongue swelling, shortness of breath, etc)
1)		
2)		
3)		
4)		
5)		

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Please circle any symptoms you have experienced recently.

CONSTITUTIONAL:
O no complaints
O chills
O fatigue
O fever
O night sweats

Eyes, Ears, Nose & Throat:
O no complaints
O watery eyes
O nasal congestion
O nasal ulcers
O oral ulcers
O other
O dry eyes
O itchy eyes
O sinus pressure
O dry mouth
O sore throat

CARDIOVASCULAR:
O no complaints
O chest pain
O palpitations
O racing heart rate
O other

PULMONARY:
O no complaints
O wheezing
O pleurisy
O shortness of breath
O cough
O other

GASTROINTESTINAL:
O no complaints
O vomiting
O constipation
O heartburn
O nausea
O diarrhea
O abdominal pain
O other

GENITAL/URINARY:
O no complaints
O painful urination
O blood in urine
O frequent urination
O previous miscarriage(s)
O other

PSYCHIATRIC:
O no complaints
O depression
O anxiety
O panic attacks
O other

MUSCULOSKELETAL:
O no complaints
O joint pain
O joint swelling
O joint stiffness
O worse in the morning
O worse in the evening
O improved with activity
O improved with rest
O muscle aches
O other

NEURO:
O no complaints
O seizures
O sensation abnormalities
O headache
O weakness
O other

HEME:
O no complaints
O easy bruising
O history of blood clots (DVT)
O other

LYMPHATICS:
O no complaints
O swollen lymph nodes

ENDOCRINE:
O no complaints
O heat intolerance
O cold intolerance
O unexpected weight loss
O unexpected weight gain
O excessive thirst
O other

DERM:
O no complaints
O hives
O psoriasis
O eczema
O sun sensitivity
O other

SLEEP:
O no complaints
O problems sleeping
O snoring
O excessive sleepiness during the day
O other

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Name _____ **Date of Birth** _____ **Date** _____

Social History

Please provide information about your home. Please circle all that apply.

My home is less than 10 years old. My home is older than 10 years old.

Carpet No Carpet

Carpet in the bedrooms only. Tile Floors

Hardwood Floors

Do you drink alcohol? If you drink alcohol, on average, how much do you drink?

No, I do not drink alcohol. Yes, I drink alcohol.

I drink less than one drink daily. I drink one drink daily.

I drink more than one drink daily.

Have you ever smoked or been exposed to second hand smoke?

No Smoking history No significant second hand smoke exposure

Previous Smoker: approximate date of last tobacco use:_____

Less than one pack per day. One pack per day.

More than one pack per day. Second hand smoke exposure.

Are you married, or have you previously been married?

Single Married Divorced Widowed Other

Do you have pets or regular exposure to any animals or insects?
Please circle all that apply.

Dog(s) Cat(s) Bird(s) Horse(s) Cow(s)

Rabbit(s) Mice Cockroaches Other

Do you have day care exposure (either directly or indirectly through your child)?

Yes No

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Family History

What diseases/medical problems are in your family's history? Please identify the family member's relation to you.

Medical Condition **Family Member(s), example: Mother, Father, Sister**

Arthritis:_____

Lupus:_____

Autoimmune Disease:_____

Asthma:_____

Allergies:_____

Lung Disease:_____

Infections:_____

Heart Disease:_____

Thyroid Disease:_____

Diabetes:_____

Cancer:_____

Other:_____

Please list all of your medications, dosage, and how you take them.

Examples: Prednisone 10mg tablet; two tablets twice a day. Flonase 2sprays/nostril; once a day.

_____

_____

_____

_____

_____

_____

_____

_____

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