STAAMP
SOUTH TEXAS
Allergy & Asthma
MEDICAL PROFESSIONALS

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Date: _____ **Patient's Name:** _____ **Age:** _____

Patient's Primary MD: _____ **Practice Type:** GP FP Internist Peds

Other: _____

Who referred you to this clinic? Self-referred Primary MD **Other:** _____

The patient's problems are (check all that applies):

- ☐ Nose symptoms *Age when started*____
- ☐ Sinus symptoms *Age when started*____
- ☐ Cough *Age when started*____
- ☐ Difficulty breathing *Age when started*____
- ☐ Asthma/Wheezing *Age when started*____
- ☐ Recurring infections *Age when started*____
- ☐ Other problems: _____
- ☐ Hives or Swelling of skin *Age when started*____
- ☐ Persistent Rash or Eczema *Age when started*____
- ☐ Food Reactions *Age when started*____
- ☐ Drug Allergy *Age when started*____
- ☐ Insect Sting Allergy *Age when started*____

The patient's symptoms are present during:

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter
- ☐ All Year
- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Night
- ☐ All Day

I believe the following trigger the patient's symptoms:

- ☐ Trees
- ☐ Grasses
- ☐ Weeds
- ☐ Molds
- ☐ Dogs
- ☐ Cats
- ☐ Dust
- ☐ Being Indoors
- ☐ Being Outdoors
- ☐ School
- ☐ Workplace
- ☐ Strong Odors
- ☐ Weather Changes
- ☐ Strong Emotions

Does the patient smoke? **Yes** **No**

Does anyone around the patient smoke? **Yes** **No**
If "Yes" please list who: _____

Is the patient exposed to any animals? **Yes** **No**
If "Yes" please list: _____

Is the patient exposed to any of the following?
Fireplace Wood-burning stove Strong fumes/chemicals Pollution

Please indicate the patient's specific symptoms/Review of Systems (check all that apply):

General
- ☐ Fever
- ☐ Chills
- ☐ Fatigue

Nose
- ☐ Stuffy nose (Congestion)
- ☐ Mouth breathing
- ☐ Frequent sneezing
- ☐ Nose itching
- ☐ Nose rubbing
- ☐ Runny nose
- ☐ Loud snoring
- ☐ Frequent sniffling
- ☐ Unable to smell
- ☐ Nasal polyps
- ☐ Sinus pain

Ears
- ☐ Stuffiness or ear popping
- ☐ Frequent ear infections
- ☐ Earache
- ☐ Hearing loss
- ☐ Dizziness

Skin
- ☐ Eczema (Atopic Dermatitis)
- ☐ Rash
- ☐ Hives
- ☐ Swelling
- ☐ Itching

Gastrointestinal
- ☐ History of food reactions
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Abdominal Pain/Cramping
- ☐ Constipation
- ☐ Heartburn

Eyes
- ☐ Itching
- ☐ Watering
- ☐ Redness and irritation
- ☐ Yellow mucus in eyes
- ☐ Dryness and burning
- ☐ Blurred vision
- ☐ Puffiness of eyelids

Throat and Mouth
- ☐ Roof of mouth itches
- ☐ Throat itches or tickles
- ☐ Postnasal drip
- ☐ Throat clearing
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Loss of taste
- ☐ Throat infections

Lungs
- ☐ Chest symptoms with exercise
- ☐ Coughing at night
- ☐ Coughing during the day
- ☐ Coughing up sputum/mucus
- ☐ Pain or tightness in chest
- ☐ Wheezing
- ☐ Difficulty breathing

Heart
- ☐ Chest pain
- ☐ Palpitations/racing heartbeat

Muscle and Bone
- ☐ Body aches
- ☐ Arthritis
- ☐ Back pain

Neurologic
- ☐ Headache
- ☐ Migraines

Previous Allergy History

Has the patient ever been tested for allergies in the past? **Yes** **No** If "Yes" when? _____

Has the patient ever been on allergy shots in the past? **Yes** **No** If "Yes" when? _____

What medicine(s) has the patient been on in the past?

Antihistamines
- ☐ Zyrtec (cetirizine)
- ☐ Xyzal (levocetirizine)
- ☐ Claritin (loratadine)
- ☐ Clarinex (desloratadine)
- ☐ Allegra (fexofenadine)

Antihistamine/Decongestant
- ☐ Zyrtec-D
- ☐ Claritin-D
- ☐ Clarinex-D
- ☐ Allegra-D
- ☐ Sudafed

Nasal Steroid Sprays
- ☐ Flonase (fluticasone)
- ☐ Nasonex (mometasone)
- ☐ Rhinocort
- ☐ Nasocort
- ☐ Veramyst
- ☐ Omnaris
- ☐ Qnasl

Nasal Antihistamines
- ☐ Astelin (azelastine)
- ☐ Astepro
- ☐ Patanase (olopatadine)

Other
- ☐ Singulair (montelukast)
- ☐ Dymista Spray
- ☐ Afrin nose spray

Please List Others:

_____
_____
_____

Medical History

Please indicate any past or current medical issues for <u>the patient</u>:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ High cholesterol
- ☐ Diabetes
- ☐ Heartburn (GERD, Reflux)
- ☐ ADHD
- ☐ Anxiety
- ☐ Depression
- ☐ Anemia/Bleeding
- ☐ Blood clots
- ☐ Arthritis
- ☐ Thyroid disease

Others (please list): _____

_____

Please list any surgeries the patient has had and indicate their age at the time:

_____

_____

Please list any significant injuries the patient has had to their head or chest (eg., broken nose, etc):

_____

_____

Family History

Does anyone in **<u>the patient's</u>** immediate family have any of the following problems?

	Nasal allergies	Sinus problems	Asthma	Food allergies	Eczema	Hives
Patient's Mother	☐	☐	☐	☐	☐	☐
Patient's Father	☐	☐	☐	☐	☐	☐
Brothers	☐	☐	☐	☐	☐	☐
Sisters	☐	☐	☐	☐	☐	☐
Patient's Children	☐	☐	☐	☐	☐	☐

Social History

If the patient is a minor, who has custody? _____

Who does the patient live with? _____

All 3 pages reviewed by provider: _____ Date: _____