

DuPage Medical Group

ASTHMA & ALLERGY CENTER

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Dr. Jacqueline Moran Dr. Brian Smart Dr. Thomas Van Osdol

Patient History (Adult)

Pt. Name: _____

Please take a few moments to complete the following **two page** patient questionnaire. Thank you.

Primary Care Provider: _____ **Referred by:** _____

What medical concerns would like addressed during today's visit (Chief Complaint)?

Please list your current and past **medical problems** and any prior **surgeries**:

Please list your current **medications** including dosages (if known). Please include any supplements, herbs, vitamins, etc.

MEDICATION ALLERGIES:

ENVIRONMENTAL ALLERGIES:

Please help us get to know you and your home environment a little better.

Personal History:

Marital status: _____

Children: number/ages _____

Occupation (s): _____

Alcohol use: Yes No

Tobacco/smoking history:

1. Previous use: Yes No

Quit date: _____

2. Current use: Yes No

If "yes," are you interested in quitting?

Yes No

3. Packs per day/years: _____

Hobbies/Interests:

Home Environment:

Live in: apt, house etc.. _____

Indoor animals: Yes No List: _____

Indoor smokers: Yes No List: _____

History of indoor water damage and/or indoor mold:

Yes No

If yes, explain: _____

Do you use "dust mite covers" for bedding:

Yes No

Heating and cooling (central or window AC, gas or electric heat, fireplace etc.): _____

Flooring (carpet, laminate, tile, wood, etc.): _____

FAMILY MEDICAL HISTORY:

Do immediate family members have any of the conditions listed below (do not include yourself)?

Condition:	Family history:	Who (i.e. mother, father, siblings, children, etc):
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sinus problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other lung disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Thyroid problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Autoimmune disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Immune deficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Migraines	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Other	Explain:	

REVIEW of SYSTEMS:Please **check Yes or No** to indicate if you **currently** have any problems in one or more of the following areas. If yes, please **circle** and/or briefly explain the problem.

Organ system:	Yes or No	If yes, please circle all that apply:
General health:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Recurrent fever, chills, sweats, unexplained weight loss, weight gain, excessive fatigue, sleep problems
Eyes:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Blurred vision, eye pain, eye discharge, redness, watering, matting/crusting, itching, gritty sensation, eyelid rash/swelling
Ears/nose/throat:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing loss, earache, nasal congestion, nose bleeds, abnormal taste/smell, nasal drip, post nasal drip, allergies, dry mouth, sores in mouth, sore throat, hoarseness, throat clearing
Cardiovascular:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Irregular heart beats, hypertension, heart problems, stroke
Respiratory:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Asthma, emphysema, chronic bronchitis, cough, wheezing, shortness of breath, exercise difficulties
Gastrointestinal:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Reflux/heartburn, difficulty swallowing, nausea, vomiting, diarrhea, constipation, ulcers
Genitourinary:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Painful urination, frequent urination, incontinence due to coughing
Musculoskeletal:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Arthritis, joint pain, muscle pain, cramps, joint stiffness, joint swelling
Skin:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Dryness, rashes, itching, redness, swelling, change in moles
Neurology:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Headache, numbness/tingling, weakness, dizziness, lightheadedness
Psychiatry:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anxiety, depression
Endocrine:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Excessive thirst, cold intolerance, diabetes
Hematology:	<input type="checkbox"/> Yes <input type="checkbox"/> No	Anemia, bleeding problems, enlarged lymph nodes

Physician Notes: _____

 I have reviewed the information above._____
Physician Signature_____
Date