THE OHIO STATE UNIVERSITY
WEXNER MEDICAL CENTER

The Ohio State University Wexner Medical Center
OSU Department of Otolaryngology–Head and Neck Surgery
Division of Sinus and Allergy at the OSU Eye and Ear Institute
915 Olentangy River Rd. 4th Floor Columbus, Oh 43212
614-366-ENTS (3687)

Patient Home History Form

General Information

Date: _____ **Patient's Name:** _____ **Date of Birth:**_____
Preferred name: _____ **Age:** _____ **Sex: M / F** **Marital Status S /M /D /Sep /W**
Parent's name (if <18): _____ **Occupation:** _____
Address: _____**City:** _____ **State:** _____ **Zip code:** _____
Phone - Home (___)_____ **Mobile** (___)_____ **Work** (___)_____**Referred by** _____

*****Please have any pertinent previous testing results faxed to 614-293-9698, Attention: Allergy**

Medical Information

What problems are you having? (List each complaint, how and/or when it first started)

1._____
2._____
3._____

Nose
___ Stuffy
___ Runny
___ Itching

Mouth
___ Roof itch
___ Throat itch
___ Lips swell

Itching
___ Feet or Hands
___ Face
___ Between shoulders

Cough
___ Year round
___ Seasonal
___ Worse after a cold

Ears
___ Stopped up
___ Itching
___ Sore

Nasal Blocking
__ _Constant
___ Nighttime
___ After meals
___ Year round

Sneezing
___ Year round
___ Seasonal
___ Smoky places
___ Dust

General symptoms
___ Pain, where_____
___ Frequent colds
___ Tire out easily
___ Trouble sleeping

Eyes
___ Water
___ Itch
___ Swelling
___ Burn

Lungs
___Wheezing
___Chest tightness
___SOB w exercise

Skin
___Scaly rash
___Hives
___Nickel or metal allergy
___Latex sensitive?

(Check situations that make your allergies worse)

___ Outdoors
___ Indoors
___ After getting into bed
___ Mowing or out in grass
___ Spring

___ When vacuuming
___ When dusting
___ Cold weather
___ With temperature changes
___ Summer

___ Windy days
___ Rainy days
___ Damp places
___ Basements
___ Fall

___ With weather changes
___ Near a barn
___ Winter
___ Worse around animals, which ones:

Are you allergic to any medications? If yes, Please list and describe how they affect you.

1. _____

2. _____

Are you allergic to any insect stings? Please list and describe how they affect you _____

Medicines

List any prescription and non prescription medications you take. Remember to include eye drops, nasal sprays, vitamins, herbal medications and ointments.

_____

_____

What other medications or treatment have you tried in the past for these problems? Which did and didn't help?

_____

_____

Do you smoke? Cigarettes Y / N ___ #/day, Cigars Y / N ___ #/day, Pipe Y / N ___#/day, # of years smoked ____
Quit smoking _____ years ago Does anyone at work or in your home smoke? Y / N
Do you drink alcohol? Wine Y / N -_____ #/week, Liquor Y / N-_____ #/week, Beer Y / N- _____ #/week

Have you ever had Allergy Testing? Yes / No If yes, when?_____ Were any tests positive? Yes / No

If yes, what were you allergic to? _____

Are you allergic to any Shellfish? If yes, which ones?_____

Are you allergic to any other food? Yes / No If yes, which ones?_____

Mark any that occur after ingesting certain foods:____ Rash/Hives, ____Lip Swelling, ____Difficulty Breathing, ____ Itching of mouth/throat, ____ Nausea/ Vomiting, ____ Diarrhea, ____ Abdominal Cramping

List surgeries and hospitalizations not already in your medical record here at OSU

Date	Type of Surgery	Reason

Are you around any animals?

__ Cat __ Dog __ Horse __ Gerbil __ Bird __ Hamster __ Rabbit __ Cockroach __ Mouse __ Rat

Check any of the following that aggravate your symptoms.

__ Paint fumes __ Perfume __ Mowing lawns __ Smoke __ Strong odors __ Cleaning products

Family History (Circle any relatives that have allergic symptoms, Star * any who have Asthma)

Father	Brother 1	Sister 1	**Father's side:**	Aunt	**Mother's side:**	Aunt
Mother	Brother 2	Sister 2	Grandfather	Gr. Grandfather	Grandfather	Gr.Grandfather
Son 1	Daughter 1	Son 1	Grandmother	Gr.Grandmother	Grandmother	Gr.Grandmother
Son 2	Daughter 2	Son 2	Uncle	Cousin	Uncle	Cousin

Have you ever had a sleep study? Yes / No If yes, what was the result? _____

Environmental Exposures

Home
__ Single family
__ Apartment, floor # ___
__ Trailer
__ Dorm room

___ On a Slab
___ Basement
___ Central air
___ Wallpaper

___ Age of dwelling
___ Years lived there?_____
___ Central heat gas / electric
___ Houseplants
___ Dehumidifier

Location: __City __Country __Farm
___ Central heat gas / electric
___ Washer / Dryer, gas / electric
___ Waterbed __standard mattress
___ Down/feather pillows, blankets

Chemicals Used- in home
___ Roach
___ Chlorine cleansers
___ Household cleaners
___ Air fresheners
___ Aerosols

Chemicals used - outside
___ Ant spray
___ Bug sprays
___Tree & bush sprays
___Yard chemicals

Mark medical conditions you have experienced in the past (P) or now (N) have:

___ Anesthesia problems
___ Asthma
___ Arthritis
___ Bleeding problems
___ Broken nose
___ Bronchitis
___ Cancer
___ Colitis
___ COPD
___ Croup
___ Deviated septum
___ Diabetes
___ Eczema
___ Emphysema
___ Glaucoma
___ Hives
___ High Blood Pressure
___ Hay Fever
___ Headaches, frequent
___ Headaches, migraine
___ Heart Burn or reflux
___ Heart Disease
___ Immune problems
___ Milk Allergy
___ Nasal polyps
___ Nasal surgery
___ Psoriasis
___ Reactive Airway disease
___ Seizures
___ Sinus disease
___ Skin disease
___ Skin rash
___ Sleep Apnea
___ Snoring
___ Thyroid dysfunction
___ Other:_____

Systems review

Stomach and Intestines _____ Check here if no problems in this area

Appetite
___ Good
___ Picky
___ Poor

Bowels
___ Regular
___ Constipated
___ Diarrhea

Mouth
___ Offensive breath
___ Swallowing trouble
___ Canker or cold Sores

Stomach
___ Nausea
___ Vomiting
___ Indigestion
___ Gas
___ Bloating

Heart and Lung _____ Check here if no problems in this area

Difficult Breathing
__ Day
__ Night
__ Use pillows to sleep,#__
__ During or after exercise

Weight Loss / Gain
__ How much
__ Intentional
__ Unintentional
__ Take diet pills

Chest Pain
__ During exercise
__ Location
__ Radiates
__ See cardiologist

Swelling
__ Legs, __am__pm
__ Feet, __am__pm
__ Hands, __am__pm
__ Eyes, __am__pm

If you have skin problems, list names of products you can and cannot use:

Can't use: Cosmetics: _____ Laundry: _____ Bath: _____ Personal care: _____

Neurological ____ Check here if no problems in this area

Headaches: ___Yes ___ No

Started when? _____

How often do they occur? _____

Related to anything? _____

Accompanied by? ___ Dizziness

___ Ringing noises

___ Nausea or Vomiting

___Light hurting eyes

How severe? _____

Where does it hurt? _____

Does anything help? _____

Musculoskeletal

__ Muscle or joint pain, Where _____

__ Bursitis, Where _____

__Arthritis, where_____

Urination ____ Check here if no problems in this area

___Infections ___Painful ___Frequent ___Delayed ___Prolonged ___Bed wetting

Please complete the following Quality of Life Score:

Over the last 2 weeks, have any of these symptoms been a problem for you? Please check correct answer.	**No 0**	**Mild / Slight 1**	**Moderate 2**	**Severe 3**
Sneezing				
Runny Nose				
Need to blow nose				
Facial pain / pressure				
Thick-nasal drainage				
Cough				
Post nasal drainage				
Dizziness				
Ear pain				
Ear fullness				
Difficulty falling asleep				
Waking up at night				
Wake up tired				
Lack of good night's sleep				
Fatigue				
Reduced productivity				
Reduced concentration				
Frustrated / restless / irritable				
Sad				
Embarrassed				
Total Score				

Reviewed with patient: _____ **Date:** _____