UCSF Medical Center

UCSF Benioff Children's Hospital

Patient:

MRN:

DOB:

(Place UCSF Patient Label Here)

Reason For Visit (Check the box that states the main reason for your visit)

☐ Nasal allergy symptoms ☐ Asthma ☐ Sinus problem ☐ Food allergy

☐ Medication allergy ☐ Hives and/or swelling ☐ Recurrent infections

☐ Other: (Please list)

Allergies

Are you allergic to any medication(s)? ☐ No ☐ Yes If yes, please list

Medication(s):	Reaction:	Date of Reaction:
_____	_____	_____
_____	_____	_____

Pharmacy

Pharmacy Name:

Phone: Fax:

Address:

Medications (Please list your medications below)

Name of Medication	Strength/Dose	Directions (Times taken a day)

Please attach a separate piece of paper for additional medications.

Past Medical History (List hospitalizations, serious illnesses, operations, and injuries beginning		
Past medical history	**Month/year**	**Comments**

Past Medical History (including childhood):
Check if you ever had any of the following: ☐ Asthma ☐ Eczema ☐ Ear Infections ☐ Sinusitis ☐ Bronchitis ☐ Pneumonia ☐ Hives

Family History (List major family illnesses/diseases such as diabetes, heart disease, cancer, etc.)			
Relationship	**Age (if alive)**	**Age of death**	**Health Problems**
Father			
Mother			
Brother			
Sister			
Child			
Child			
Comments (e.g. Adopted)			

Alcohol Use

Do you drink alcohol? ☐ Yes ☐ No

If yes, answer the following questions

Drinks/week: _____ Glasses of wine
_____ Cans of beer
_____ Shots of liquor
_____ Drinks containing 0.5 oz. liquid not included above

Drug Use

Do you use any drugs such as marijuana, cocaine, stimulants or sedatives? ☐ Yes ☐ No

If yes, list types: _____

How many times per week do you use above drugs? _____

Have you ever injected any drugs? ☐ Yes ☐ No

Tobacco Use

Please check what type of exposure(s) you have had to tobacco:

☐ Never smoked ☐ Former smoker ☐ Passive smoker (regular exposure)

☐ Current every day smoker ☐ Current some days smoker

Types: ☐ Cigarettes ☐ Pipe ☐ Cigars ☐ Other: _____

Packs/Day: _____ Years: _____

Smokeless Tobacco: ☐ Snuff ☐ Chew

Date Quit: _____ Interested in quitting? ☐ Yes ☐ No

Sexual History:

Are you currently sexually active? ☐ Yes ☐ No

Partners (check all that apply): ☐ Male ☐ Female

Women only: What type of birth control do you use: _____ ☐ None

Employment

Occupation: _____

☐ Retired: List year: _____ from work as: _____

☐ Disabled: List Year: _____ by (describe): _____

Please check any illness, problems, or symptoms you have had in the past month

GENERAL SYMPTOMS

- ☐Activity change
- ☐Appetite change
- ☐Chills
- ☐Night sweats
- ☐Fatigue/tiredness
- ☐Fever
- ☐Unexpected weight change

HEAD/EARS/NOSE/THROAT

- ☐Congestion
- ☐Dental problem
- ☐Drooling
- ☐Ear drainage
- ☐Ear pain
- ☐Facial swelling
- ☐Hearing loss
- ☐Mouth sores
- ☐Nosebleeds
- ☐Postnasal drip
- ☐Runny nose
- ☐Sinus pain
- ☐Sinus pressure
- ☐Sneezing
- ☐Sore throat
- ☐Ear ringing
- ☐Trouble swallowing
- ☐Voice change

EYES

- ☐Eye discharge
- ☐Eye itching
- ☐Eye pain
- ☐Eye redness
- ☐Light sensitivity
- ☐Change in vision

LUNGS/BREATHING

- ☐Snoring
- ☐Chest tightness
- ☐Choking
- ☐Cough
- ☐Shortness of breath
- ☐Noisy breathing
- ☐Wheezing

HEART

- ☐Chest pain
- ☐Leg swelling
- ☐Palpitations/abnormal heart beats

STOMACH/INTESTINE

- ☐Stomach swelling
- ☐Stomach pain
- ☐Anal bleeding
- ☐Blood in stool
- ☐Constipation
- ☐Diarrhea
- ☐Nausea
- ☐Rectal pain
- ☐Vomiting

ENDOCRINE

- ☐Cold intolerance
- ☐Heat intolerance
- ☐Excessive thirst
- ☐Excessive hunger
- ☐Frequent urination

GENITOURINARY

- ☐Difficulty urinating
- ☐Pain with urination
- ☐Involuntary urination
- ☐Flank pain/side pain
- ☐Frequent urination
- ☐Genital sores
- ☐Blood in urine
- ☐Urinary urgency
- ☐Decreased urine

MUSCULAR

- ☐Joint pain
- ☐Back pain
- ☐Abnormal gait/walking
- ☐Joint swelling
- ☐Muscle pain
- ☐Neck pain
- ☐Neck stiffness

SKIN

- ☐Color change
- ☐Pale skin color
- ☐Rash
- ☐Skin wounds/ulcers

ALLERGY/IMMUNOLOGY

- ☐Environmental allergies
- ☐Food allergies
- ☐Abnormal immune system

NEUROLOGIC

- ☐Dizziness
- ☐Facial asymmetry
- ☐Headaches
- ☐Light-headed
- ☐Numbness
- ☐Seizures
- ☐Speech problems
- ☐Fainting
- ☐Tremors/shaking
- ☐Weakness

HEMATOLOGY

- ☐Lymph node swelling
- ☐Bruises/bleeds easily

MOOD/PSYCHIATRIC

- ☐Agitation
- ☐Behavior problem
- ☐Confusion
- ☐Difficulty concentrating
- ☐Depression
- ☐Hallucinations
- ☐Hyperactive
- ☐Nervous/anxious
- ☐Self-injury
- ☐Sleep problems
- ☐Suicidal ideas

Please answer the following questions

In what season(s) do your symptoms worsen?

☐ Spring ☐ Summer ☐ Fall ☐ Winter ☐ All year

Have you ever had any previous allergy testing?

☐ No ☐ Yes, date: _____ Doctor: _____

Have you ever been on allergy shots/vaccines?

☐ No ☐ Yes, date started: _____ Date Started: _____

Did you feel that the allergy shots/vaccines worked? ☐ No ☐ Yes

Have you ever had any reactions to vaccines?

☐ No ☐ Yes, describe _____

Have you ever had any reactions to latex (gloves, balloons, condom, and diaphragm)?

☐ No ☐ Yes, describe _____

Have you ever had any insect sting or bite reactions?

☐ No ☐ Yes, describe _____

Have you ever had any food reactions?

☐ No ☐ Yes, describe _____

Environment

What kind of home do you live in?

☐ House ☐ Apartment ☐ Mobile home ☐ Other: _____

How old is your home? _____ years.

How long have you been living in your current residence? _____ years.

Please check <u>all</u> the boxes that describe your environment.

☐ Feather pillows ☐ Down comforter ☐ Carpet on bedroom floor ☐ Area rugs

☐ Dust proof mattress cover

Pets

☐ Cat(s) ☐ Dog(s) ☐ Other pets (list)_____

Air conditioning

☐ None ☐ Central ☐ Window

Humidifier

☐ None ☐ Central ☐ Single room unit

Type of heating

☐ Forced hot water ☐ Forced hot air ☐ Electric baseboard ☐ Space heater

Work environment

☐ Office ☐ Other, please describe _____

☐ Old ☐ Dusty ☐ Damp ☐ Visible mold

Made accessible
1/23