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 with your childhood and working forward in time)		
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