

Baltimore Ear, Nose, Throat and Allergy

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Date: _____ Referred by: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ For How Long: _____

Social Security # _____

Main Complaint: _____

Prior Allergy Treatment or Testing: Yes/No (if yes where and when): _____

Other Medical Problems: _____

List Major Surgeries and Dates: _____

List **ALL** medications including herbs and vitamins now being taken: _____

CIRCLE ALL SYMPTOMS YOU HAVE EXPERIENCED:

Nose: Itching – sneezing – nasal congestion (stuffy) – runny nose – post nasal discharge – redness – frequent “colds” – polyps – sinus trouble - sinus infections _____ # per year

Eyes: Itching outer corner - Itching inner corner – puffiness - blurred vision - excessive tearing – discharge - visual disturbances

Ears: Itching - itching deep in ears - tinnitus (ringing) – dizziness – popping – fullness – pressure - hearing loss - drainage (discharge) - red frequent infections _____ # per year

Mouth & Throat: Frequent sore throats - itching of palate or back of throat - difficulty swallowing - lump sensation – laryngitis - need to clear mucous in the morning - mouth ulcers swelling of lips swelling of tongue - scratchy or burning sensation

Chest: Cough – wheezing - shortness of breath - pain-tightness – asthma - frequent chest colds or infections - chronic obstructive pulmonary disease (COPD) - frequent attacks of bronchitis _____ # per year

Gastro-Intestinal: Belching – bloating – heartburn - retasting of foods – cramping - bad breath - excessive gas – diarrhea – constipation - poor appetite - irritable bowel syndrome

Genito-Urinary: Difficulty voiding – frequency – urgency – burning – prastasis – vaginitis - itching
frequent urinary infections - frequent yeast infections

Skin: Hives – rashes – eczema – swelling – itching - reactions to cosmetics - blisters or peeling of hands - athlete’s foot-jock itch

Neurological: Headache (sinus – migraine - tension) - decreased attention span - learning disability – seizures - inability to concentrate - poor memory

Miscellaneous: Joint pain - muscle pain – arthritis - restless legs - chronic fatigue - insomnia

ANSWER ALL QUESTIONS WHICH PERTAIN TO YOU:

Seasonal Incidence

Do you have trouble or is your condition worse:

- | | | |
|------------------|-----|----|
| 1) In the Spring | Yes | No |
| 2) In the Summer | Yes | No |
| 3) In the Fall | Yes | No |
| 4) In the Winter | Yes | No |

Describe your allergy “attack” symptoms:

- | | | |
|--|-----|----|
| 1) Do your attacks last | | |
| A few minutes | Yes | No |
| Several hours | Yes | No |
| Several Days | Yes | No |
| A whole season | Yes | No |
| The whole year | Yes | No |
| 2) Do the attacks occur regularly at a particular time of day or night | Yes | No |
| 3) Have you found anything, which will relieve the attacks | Yes | No |
| 4) Will the attacks cause you to lose sleep | Yes | No |
| 5) Will the attacks interrupt your daily routine | Yes | No |

Childhood History

- | | | |
|--|-----|----|
| 1) Did you have eczema | Yes | No |
| 2) Did you have colic | Yes | No |
| 3) Were you often sick | Yes | No |
| 4) Did you have bronchitis or asthma | Yes | No |
| 5) Did you have croup | Yes | No |
| 6) Did you have frequent attacks of “stomach ache”, diarrhea or vomiting | Yes | No |
| 7) Did you have frequent colds | Yes | No |
| 8) Did you have frequent ear infections | Yes | No |
| 9) Did you have sinus trouble | Yes | No |
| 10) Did you have frequent sore throats | Yes | No |

Family History

Have any members of your family (this includes mother, father, grandparents, aunts, uncles, brothers, sisters and children) had any of the following diseases:

- | | | |
|--|-----|----|
| 1) Asthma | Yes | No |
| 2) Hay Fever | Yes | No |
| 3) Nasal Allergy (frequent attacks of sneezing, runny nose, blockage of nose, post nasal drip) | Yes | No |
| 4) Hives | Yes | No |

- | | | |
|-------------------------|-----|----|
| 5) Eczema | Yes | No |
| 6) Chronic skin disease | Yes | No |
| 7) Frequent headaches | Yes | No |
| 8) Migraine | Yes | No |

Non-pollen Inhabitant History

House Dust

Do you notice that your trouble begins or is aggravated:

- | | | |
|--|-----|----|
| 1) When the house is being cleaned or swept | Yes | No |
| 2) When rugs are being cleaned | Yes | No |
| 3) When the bed is being made or the mattress being turned | Yes | No |
| 4) During spring house cleaning | Yes | No |
| 5) When you sit on old overstuffed furniture | Yes | No |
| 6) In dusty places such as: theaters, churches, grocery stores, department stores, libraries, your bedroom | Yes | No |

Atmospheric Mold

Do you notice that your trouble begins or is aggravated

- | | | |
|---|-----|----|
| 1) During prolonged periods of damp or humid weather | Yes | No |
| 2) When you are around where grass is being mowed or weeds are being cut | Yes | No |
| 3) When you are near hay or straw (as at the circus, in a barn around a hay stack, on a hay ride) | Yes | No |
| 4) When you go in an old damp house, a damp basement, shed or cellar | Yes | No |
| 5) When you enter a closet in which are stored old shoes, unused luggage, gloves or other leather goods | Yes | No |
| 6) If you eat cheese, mushrooms, cantaloupe or drink beer | Yes | No |
| 7) When the first cold snap of autumn occurs | Yes | No |

Animals

Do you notice that your trouble begins or is aggravated:

- | | | |
|--|-----|----|
| 1) When lying on a feather pillow | Yes | No |
| 2) When fluffing pillows | Yes | No |
| 3) If you use a down comforter | Yes | No |
| 4) If you are near chickens, ducks, geese, pigeons, parrots, turkeys, canaries, or other birds | Yes | No |
| 5) If you are around anyone who works around poultry or other fowl | Yes | No |
| 6) Do you have pets in the house or yard | Yes | No |
| 7) When you are around any of the following animals: dogs, cats, horses, goats, rabbits, cows, hogs or sheep | Yes | No |
| 8) When you handle or come into contact with any of the following: furs, rugs, certain articles of clothing, dress goods, blankets, gloves, hats, toy animals or brushes | Yes | No |

Smoke

Do you notice that your trouble begins or is aggravated:

- | | | |
|--|-----|----|
| 1) Do you smoke | Yes | No |
| 2) When you are in night clubs or other smoky places | Yes | No |

Orris Root

Do you notice that your trouble begins or is aggravated:

- | | | |
|--|-----|----|
| 1) When using face, talcum, body, bath or tooth powder | Yes | No |
| 2) In beauty parlors or barber shops | Yes | No |

3) When around people who use a lot of powder perfume Yes No

Pyrethrum-Orris Root-Lethane-Paradichlorobenzene

Do you notice that your trouble begins or is aggravated:

- 1) When you are exposed to household insect powders or sprays Yes No
- 2) When you are exposed to powders, sprays or crystals used for moth proofing purposes Yes No
- 3) When you are exposed to dusting powders or sprays used in the gardens or on crops Yes No

Food History

- 1) Do you suspect any food is causing or aggravating your condition Yes No
- 2) Are there any foods which you dislike Yes No
- 3) Are there any foods in which you over-indulge or eat frequently because you like them so much Yes No
- 4) Is there any seasonal food (for example strawberries) in which you over-indulge Yes No
- 5) Are there any foods you find difficult to digest Yes No
- 6) Do any foods you eat cause nausea, vomiting, diarrhea, heartburn, belching, gas on the stomach, cramps, hives, skin rashes, headaches (circle those that apply) Yes No
- 7) Are you on any type of diet at present Yes No

Physical History

Does your trouble at times seem to begin or become aggravated:

- 1) By change in weather Yes No
- 2) By exercise Yes No
- 3) By fatigue Yes No
- 4) By loss of sleep Yes No
- 5) By excitement Yes No
- 6) By emotional upheaval Yes No
- 7) By a hot or cold bath Yes No
- 8) By becoming overheated Yes No
- 9) By prolonged periods of physical or mental work or prolonged stress (as when there is someone sick in the family) Yes No
- 10) As a result of "nervousness" Yes No
- 11) Air conditioning Yes No

Focal Infection History

- 1) Are you conscious of a foul odor in your nose Yes No
- 2) Do you have a dripping from the back of your nose into your throat which has a "sickening sweet" taste or is yellow or green like pus Yes No

Environmental Survey

- 1) Is your home old Yes No
- 2) Is your home new Yes No
- 3) Is your house damp Yes No
- 4) Is your house dry Yes No
- 5) Do things mildew easily around the house Yes No
- 6) Near your house is there
 - A factory Yes No
 - A railroad Yes No
 - A lake Yes No

A poultry yard	Yes	No
A swampy area	Yes	No
Lots of weeds	Yes	No
Anything you suspect as a possible cause of your symptoms	Yes	No
7) Is your house heated by:		
Open gas heaters	Yes	No
Floor gas furnaces	Yes	No
Radiators	Yes	No
Open fireplaces	Yes	No
Central heating system with ducts	Yes	No
8) Is your house cooled by:		
An attic fan	Yes	No
Window air-conditioning	Yes	No
Central air-conditioning	Yes	No
Window fans	Yes	No
9) Do you have plants in the house or in window planter boxes	Yes	No
10) Do you use insect sprays or moth repellents in the house	Yes	No
11) Do you keep any books or magazines that gather dust in the house	Yes	No
12) Do you have any overstuffed furniture	Yes	No
13) Do you use feather pillows	Yes	No
14) Do you use down comforters on the bed	Yes	No
15) Do you have rugs on the floor	Yes	No
16) Do you have draperies on the windows	Yes	No
17) Do you throw pillows around the house	Yes	No
18) Are there any smells continuously or frequently present about the house	Yes	No
19) Is there anyplace in the house where you have symptoms regularly	Yes	No
20) Are the walls of your house covered with wallpaper	Yes	No
21) Is there any type of business enterprise carried out in your house	Yes	No
22) Are you engaged in a hobby at your house	Yes	No

Work or School Survey

1) Do you have symptoms at work or school	Yes	No
2) Is the place where you work or attend school		
Damp	Yes	No
Cooled with window or attic fans	Yes	No
Air-conditioned	Yes	No
Centrally heated	Yes	No
Dusty	Yes	No
Smoky	Yes	No
3) As far as you know, do you inhale anything at work or school which might cause or aggravate your symptoms	Yes	No
4) Are there any fumes, gases, smokes or odors where you work or attend school	Yes	No

Activities

1) Do you take part in any outdoor sports or hobbies	Yes	No
2) Are you better when you are away from home on a trip such as vacation time	Yes	No

Previous Treatment History

1) Have you ever had any operations for your condition	Yes	No
2) Have any of the treatments or drugs prescribed given prolonged relief	Yes	No

General Medical History

- | | | |
|--|-----|----|
| 1) Do you often have pain in the face | Yes | No |
| 2) Do you often experience flushing of the face with a sensation of warmth | Yes | No |
| 3) Do you suffer pain in the eyes | Yes | No |
| 4) Do you experience a sense of burning or dryness in the nose or sense of stuffiness, rather than actual blockage | Yes | No |
| 5) Do you often have pain inside your nose | Yes | No |
| 6) Are you bothered with a bad odor inside your nose | Yes | No |
| 7) Do you frequently blow large, dried crusts or scabs from your nose | Yes | No |
| 8) Have you ever had severe nosebleeds | Yes | No |
| 9) Have you ever fallen or been hit hard on the nose | Yes | No |
| 10) Has your nose ever been broken | Yes | No |
| 11) Have you ever been told that you have a crooked bone in your nose | Yes | No |
| 12) Have you ever had an operation on your nose or sinuses | Yes | No |
| 13) Are you bothered by a soreness or burning in your mouth | Yes | No |
| 14) Do you have bad breath at times | Yes | No |
| 15) Are you often bothered with a sensation of dryness in your mouth | Yes | No |
| 16) Is your tongue often sore | Yes | No |
| 17) Do you often find yourself grinding your teeth or do people tell you that you grind your teeth while sleeping | Yes | No |
| 18) Do you often have pain around your ears when you chew | Yes | No |
| 19) Do the glands in your neck swell when you get sore throats | Yes | No |
| 20) Have your tonsils been removed | Yes | No |
| 21) Did you ever take a breathing test | Yes | No |
| 22) Do you have chronic chest trouble (except asthma) | Yes | No |
| 23) Did you ever have T.B. (tuberculosis) | Yes | No |
| 24) Do you live with anyone who has had T.B | Yes | No |
| 25) Did you ever have a chest or lung operation | Yes | No |
| 26) Did the doctor say that you have heart trouble | Yes | No |
| 27) Do you have high blood pressure | Yes | No |
| 28) Do you have low blood pressure | Yes | No |
| 29) Do your hands and feet swell badly | Yes | No |
| 30) Do you get short of breath easily | Yes | No |
| 31) Does your heart ever beat so fast that it seems to shake your chest | Yes | No |
| 32) Do you frequently get leg cramps | Yes | No |
| 33) Is your appetite poor | Yes | No |
| 34) Have you lost weight lately | Yes | No |
| 35) Do you gain weight easily | Yes | No |
| 36) Have you ever had stomach ulcers | Yes | No |
| 37) Did you ever have rheumatic fever | Yes | No |
| 38) Do you seem to get tired faster than the average person | Yes | No |
| 39) Are you sick often | Yes | No |
| 40) Did a doctor say you were anemic | Yes | No |