



6801 S. Yosemite St., Centennial, CO 80112
 3260 E. 104th Ave., Thornton, CO 80233
 4809 Argonne St., Suite 260, Denver, CO 80249

Office: 303.773.9000
 Toll Free: 877.8IMMUNE
 Fax: 303.770.1449

Email: info@IMMUNOe.com
 Web: www.IMMUNOe.com

Name _____ DOB ____ / ____ / ____ Dr. _____

Referred by: self friend/relative by Dr. _____ (first and last name)

History of Present Illness (if needed use the back side of pages for more details)

Age: ____ years male female Occupation (if adult): _____

Main reason for this visit: _____

Upper Respiratory Symptoms:

skip to next section if none

- runny nose stuffy nose sneezing snoring
- postnasal drainage itchy eyes watery eyes
- ear popping frequent ear infections
 - tubes placed in ears: _____ (years)
- sinus infections (____ times in the past year)
 - evaluated by Ear, Nose, Throat (ENT) specialist in ____ (year)
 - sinus CT or X-Ray done: ____ (year)
 - sinus surgery done: _____ (years)

Time of year: all year spring summer fall winter

Duration: Symptoms have been occurring for ____ years

Triggers: symptoms are made worse by: _____

Medications / remedies tried (just for upper respiratory symptoms):

- | | | | |
|-------|---------------------------------|---------------------------------------|--|
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> insufficient | <input type="checkbox"/> didn't tolerate |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> insufficient | <input type="checkbox"/> didn't tolerate |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> insufficient | <input type="checkbox"/> didn't tolerate |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> insufficient | <input type="checkbox"/> didn't tolerate |

Past Allergy History: Saw an allergist ____ years ago.

- Tested positive to: pollens molds dust cats dogs foods
- Took allergy shots for ____ years. Last shot was _____ (year)
- Allergy shots helped didn't help

Lower Respiratory Symptoms:

skip to next section if none

- Past diagnoses:** asthma reactive airways disease COPD
 croup bronchitis pneumonia other: _____

Time of year: all year spring summer fall winter

Duration: symptoms have been occurring for ____ years

Triggers: symptoms are made worse by: _____

Severity: ER visits ____ times in past 2 years. Hospitalizations in ____, ____, ____

Medications / remedies tried (just for upper respiratory symptoms):

- | | | | |
|-------|---------------------------------|---------------------------------------|--|
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> insufficient | <input type="checkbox"/> didn't tolerate |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> insufficient | <input type="checkbox"/> didn't tolerate |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> insufficient | <input type="checkbox"/> didn't tolerate |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> insufficient | <input type="checkbox"/> didn't tolerate |

Rash:

skip to next section if none

History: current rash started: _____

Triggers: current rash seems worsened by: _____

Location: face cheeks neck chest abdomen
 right arm left arm right hand left hand right leg left leg
 Other: _____

Characteristics of rash:
 itchy blotchy comes and goes stays in place and spreads
 Other: _____

Severity now: same as usual better than usual worse than usual

Medications / remedies tried (just for upper respiratory symptoms):

_____	<input type="checkbox"/> helped	<input type="checkbox"/> insufficient	<input type="checkbox"/> didn't tolerate
_____	<input type="checkbox"/> helped	<input type="checkbox"/> insufficient	<input type="checkbox"/> didn't tolerate
_____	<input type="checkbox"/> helped	<input type="checkbox"/> insufficient	<input type="checkbox"/> didn't tolerate
_____	<input type="checkbox"/> helped	<input type="checkbox"/> insufficient	<input type="checkbox"/> didn't tolerate

Food or other reactions:

History and type of reactions:

skip to next section if none

	Episode #1		Episode #2		Episode #3	
	month	year	month	year	month	year
occurred at home	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
occurred away from home	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
after eating* (list at bottom of page)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
after medicine* (list at bottom of page)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
after insect sting* (list at bottom of page)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
vomiting	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
rash	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
swollen lips	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
swollen tongue	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
swollen throat	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
trouble breathing	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
feeling faint	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
reaction over within hours	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
reaction lasted days	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
took antihistamine (Benadryl)	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
required emergency room	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
given epinephrine shot	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
prescribed an EpiPen	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
*seemed to occur after:	_____		_____		_____	

Frequent Infections:

Details

skip to next section if none

If concerned about excessive infections, also ask for the form called **Immune History**

- Ear infections:** _____
 - Sinus infections:** _____
 - Throat infections:** _____
 - Strep: _____
 - thrush: _____
 - Bronchitis:** _____
 - Pneumonia:** _____
 - Gastrointestinal:** _____
 - Skin:** _____
 - Impetigo: _____
 - Shingles: _____
 - Frequent colds:** _____
- Diagnosed with: Epstein Barr virus (mono) Other: _____
- Number of courses of antibiotics in the past year: _____
- It usually takes a change in antibiotics or multiple courses to clear up Yes No

Environmental History

- ___ cats at home cat(s) are in the bedroom exposures at work: _____
- ___ dogs at home dog(s) are in the bedroom exposures at home: _____
- other animals at home: _____ damp basement at home swamp cooler mold
- patient smokes _____ packs per day for _____ years
- father smokes mother smokes spouse smokes smoking is outdoors only
- other possible irritants in the environment: _____

Past Medical History

Surgeries and year: _____

Infection history and year: _____

already listed, see previous page _____

Other Chronic Health Conditions: _____

Current medications (not listed on the previous page; include over-the-counter meds or supplements):

Allergies to medications:
_____ caused (symptoms): _____
_____ caused (symptoms): _____
_____ caused (symptoms): _____

Last time thyroid test was checked: never within past year not for _____ years

Family History check here if adopted

Mother has: allergies asthma other: _____
Father has: allergies asthma other: _____
Siblings: allergies asthma other: _____
Maternal GP allergies asthma other: _____
Paternal GP allergies asthma other: _____
Aunts allergies asthma other: _____
Uncles allergies asthma other: _____
Others: _____

Social History

Child patient: day care home school home school split custody
Adult patient: married divorced separated some alcohol use some drug use
Other important considerations: _____

Review of Systems (symptoms not noted above)

General: frequent fatigue hot or cold intolerance trouble sleeping
 observed to briefly stop breathing while sleeping

Head: headaches

Eyes: blurred vision spots in vision pain behind eyes

Ears: decreased hearing on left side right side ringing in ears

Nose: frequent nosebleeds (_____ times per month) decreased sense of smell

Mouth / Throat recurrent mouth sores trouble swallowing

Lungs: occasional sharp pain when breathing (pleurisy)

Cardiovascular: irregular pulse fingers get blue and hurt in cold weather

Gastrointestinal: stomach pains abdominal discomfort loose stools constipation

Extremities: joint pains muscle pains

Skin: dry easy bruising

Other concerns / notes