Gary C. Steven, MD, PhD, CPI

Patient Name:_____ Date: _____

ENVIRONMENTAL EXPOSURES IN THE HOME *(Please circle the appropriate number)*

I. Type of Home. Do you live in a: 1. House 2. Condominium 3. Townhouse 4. Apartment

How old is the home? _____ How long have you lived here? _____

Ventilation

II. Type of heat: 1. Forced air 2. Radiator 3. Hydronic
Heat source: 4. Gas 5. Oil 6. LP 7. Electric

III. Type of air filters: 8. Ordinary furnace filters 9. Dense fiber filters 10. HEPA-type
11. Electrostatic

IV. Air conditioning: 1. Central 2. Window 3. Wall-mounted 4. None

V. Humidification: 1. Central humidifier in the furnace 2. Ultrasonic 3. Steam
4. Evaporative 5. None

Sources of mold exposure (Please circle all that apply)

VI. Basement: 1. None 2. Wet/damp 3. Dry 4. Dehumidifier present 5. No dehumidifier
6. Cluttered/dusty 7. Kept clean 8. Fully finished 9. Partially finished 10. Unfinished

VII. Potted plants in the home: 11. None 12. Yes *(approximately how many):* _____

Bedroom

VIII. Do you sleep on: 1. Box spring and mattress 2. Mattress only 3. Air mattress
4. Waterbed 5. Crib

IX. Quilt/cover: 6. Wool blanket 7. Cotton quilt 8. Down comforter 9. Synthetic quilt
Pillow(s): 1. Cotton pillow 2. Synthetic pillow 3. Feather pillow 4.Buckwheat hull pillow
5. No pillow
Allergy covers: 6. None 7. Pillow only 8. Mattress only 9. On both pillow and mattress

X. Bedroom Flooring: 1. Carpeting 2. Hardwood floor/linoleum 3. Throw/area rugs

XI. Bedroom Windows: 1.Heavy curtains 2. Blinds/non-fabric
3. Window treatments are cleaned 3 or more times per year
4. Window treatments are not cleaned regularly

XII. Stuffed animals or plush toys in the bedroom: 1. None 2. 10 or fewer 3. More than 10

Smoking: How many household members smoke? 1. None 2. One 3. More than one

If any household members smoke, please circle the correct number:

4. All the smokers smoke outdoors all the time
5. Any smoker(s) in the home smoke only in one or two isolated rooms
6. Smoking may take place anywhere in the home; no effort is made to restrict the flow of smoke

Hobbies: Are there any exposures to irritants in the home? 1. None 2. Wood dusts 3. Glues/varnishes 4. Other *(please list):*

PETS: If you don't have any pets, circle here *(NONE)* and move on to the next page.

Please write in the number of each type of pet you may have in your home. For each pet, please enter one of the following numbers, which will help us accurately enter this information into your records:

In the "How long?" column, please enter one of the following numbers to indicate how long you have had at least one of each type of pet in your home: 1. Less than 3 months 2. Between 3 months and 1 year 3. Between 1 and 5 years 4. More than 5 years

In the "Sleep?" column, please enter one of the following numbers for where each type of pet in the home sleeps:

1. Not in the patient's bedroom 2. In the bedroom, but not in the bed 3. In bed with the patient

In the "Care?" column, please enter one of the following numbers for each type of pet in the home:

1. The patient does not groom/clean the cage for this pet
2. The patients grooms this pet or cleans its cage

	How many?	How long?	Sleep?	Care?
Dogs	_____	_____	_____	_____
Cats	_____	_____	_____	_____
Birds	_____	_____	_____	_____
Rabbits	_____	_____	_____	_____
Chinchillas	_____	_____	_____	_____
Ferrets	_____	_____	_____	_____
Hamsters	_____	_____	_____	_____
Gerbils	_____	_____	_____	_____
Rats	_____	_____	_____	_____
Guinea pigs	_____	_____	_____	_____

PAST MEDICAL HISTORY

I. If your symptoms have been present for one year or more, please indicate how your symptoms vary throughout the year (put a check in the appropriate box underneath each month). If your symptoms are new (i.e., present for less than one year), please write in the number of months your symptoms have been present, then move on to the next question. Number of months:

II. Current medical conditions. *Please circle all that apply:*

1. No medical problems
2. Anxiety
3. Arthritis
4. Depression
5. Diabetes
6. Fibromyalgia
7. Glaucoma
8. Heartburn (reflux)
9. History of heart attack
10. High cholesterol
11. High blood pressure
12. Hyperthyroidism (overactive thryroid)
13. Hypothyroidism (underactive thyroid)
14. Irritable bowel syndrome
15. Osteoporosis
16. Other medical problems

III. Previous surgery: *Please circle all that apply:*

1. No surgeries
2. Adenoidectomy; year_____
3. Appendectomy; year_____
4. Coronary bypass; year_____
5. Ear tubes; year(s)_____
6. Gall bladder; year _____
7. Hysterectomy; year _____
8. Nasal polypectomy; year_____
9. Sinus surgery; year_____
10. Tonsillectomy; year _____
11. Other surgeries (list year)_____

SOCIAL HISTORY

I. What is your occupation:
1. The patient is an infant/toddler/preschooler
2. The patient is of school age and does not work outside the home
3. I/my child do(es) not work outside the home
4. Retired

Occupation:_____

II. How long have you worked in your current job? 1. Less than 3 months 2. Between 3 months and 1 year 3. Between 1 and 5 years 4. More than 5 years

III. Are any of the following worse when you are at work: 1. None 2. Nasal symptoms 3. Breathing symptoms 4) Skin symptoms

IV. Smoking: 1. I have never smoked / The patient is a young child *(Go on to question VIII)*

2) If you currently smoke, do you smoke: *(Please indicate the amount and frequency of your smoking)*

Cigarettes: _____	1. pack(s)	2. cigarettes	3. per day	4. per week	5. per month
Cigars: _____	6. per day	7. per week	8. per month		
Pipes: _____	9. per day	10. per week	11. per month		

V. What year did you start smoking? _____

VI. If you no longer smoke, what year did you stop smoking? _____

VII. If you smoked in the past (you entered a year for both V. and VI. above) how much did you smoke on average?

Cigarettes: _____ 1. pack(s) 2. cigarettes 3. per day 4. per week 5. per month
Cigars: _____ 6. per day 7. per week 8. per month
Pipes: _____ 9. per day 10. per week 11. per month

VIII. Alcohol usage: 1. I /the pt. do(es) not drink alcoholic beverages
2. 1 – 2 alcoholic drinks per week 4. More than 1 alcoholic drink per day
3. 3 – 6 alcoholic drinks per week 5. History of alcohol abuse

IX. Caffeine usage: 1. I/The patient do(es) not drink caffeinated beverages.
I/The patient drink(s) caffeinated beverages: 1. Once or twice a week 2. Almost daily
3. Once or twice a day 4. Three to five times a day 5. 6 or more times a day

X. Recreational drug usage: 1. I/the patient do(es) not use recreational drugs 2) History of drug abuse *(please circle the type):*
Do you use: 3. Marijuana 4. Cocaine 5. Heroin 6. Other _____
7. Once or twice a month 8. Once or twice a week 9. Three to six times a week 10. At least once a day

XI. Aerobic exercise: 1. Rarely 2. Once or twice a month 3. One to three times a week
4. Four to six times a week 5.Daily

Type of exercise: 6. Aerobics 7. Bicycling 8. Jogging 9. Playing sports 10. Running 11. Walking

XII. Stress level: 1. No significant stress.
Stress due to: 2. Marital problems 3. Behavior problems of a child 4. Spouse's health problems
5. Parent's health problems 6. Poor work environment 7. Financial problems

FAMILY HISTORY

I. For each family member listed below, write in the number corresponding to each of the following conditions:
1. No allergy, asthma, skin disorder or sinus disease
2. Asthma
3. Allergic rhinitis (Hayfever)
4. Eczema
5. Hives (Urticaria)
6. Sinus disease
7. Stinging Insect anaphylaxis
8. Medication allergy
9. Food allergy
10. I have no medical information about this person

1. Father: _____ 4. Mother:_____

2. Father's parents:_____ 5. Mother's parents:_____

3. Father's side (aunts, uncles, cousins):_____ 6 .Mother's side (aunts, uncles, cousins):_____

II. How many brothers do you have: _____ How many have any of the above conditions? _____

Which of the above condition do(es) your brother(s) have? _____

III. How many sisters do you have: _____ How many have any of the above conditions? _____

Which of the above condition do(es) your sister(s) have? _____

IV. How many sons do you have: _____ How many have any of the above conditions? _____

Which of the above condition do(es) your son(s) have? _____

V. How many daughters do you have: _____

How many have any of the above conditions? _____

Which of the above condition do(es) your daughter(s) have? _____

INFLUENZA VACCINATION

Have you received a flu shot in the past year? If so, please write the approximate date (month and year are fine):

_____

ADDITIONAL INFORMATION

Language: Circle one: English French German Italian Japanese Portugese Russian Spanish

Communication Preference: Circle one: Home Phone Cell Phone Work Phone Email Mail

MEDICATIONS

Please list all prescription, over-the-counter and herbal medications you take on a regular basis, along with their milligram size and how often you take them (e.g., once a day, twice a day, etc):