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IN SLEEP MEDICINE

Date of Consult \_\_\_\_\_

## ALLERGY IMMUNOLOGY PULMONARY HISTORY

PLEASE PRINT CLEARLY, ANSWERING CAREFULLY AND COMPLETELY.

Patient Name _____	Birth Date _____
Address _____	Sex _____ Age _____
City _____ State _____	Physician _____
Cell Phone (____) _____	Home Phone _____
Place of Employment _____	Work Phone _____
Type of work _____	Position at work _____
Spouse (if applicable) _____	Referred by _____
Emergency contact, who _____	Phone Number of contact _____
Parent's Names _____	
Fathers Occupation _____	Address (if different from child) _____
Mother's Occupation _____	Address (if different from child) _____

PLEASE ANSWER ALL THE FOLLOWING QUESTIONS AS BEST YOU CAN. SOME MAY NOT APPLY TO YOU. SOME YOU MAY WANT TO DISCUSS WITH DR. BRAY IN PRIVATE. PLEASE FILL IN BLANKS AND/OR CHECK ALL POSITIVE.

**CHIEF COMPLAINT** What is your main problem?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**HISTORY OF PRESENT ILLNESS,** TELL ME MORE ABOUT YOUR PROBLEM

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long have you had your problem? \_\_\_\_\_

Are symptoms: Progressing? \_\_\_\_\_ Regressing? \_\_\_\_\_

How many physicians have you seen about your health problems in the last 5 years? Please list them and what they told you.

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**SYMPTOMS**

**EYES:** Itch \_\_\_ Burn \_\_\_ Water \_\_\_ Swell \_\_\_ Infection \_\_\_ Discharge \_\_\_ Circles \_\_\_

**EARS:** Itch \_\_\_ Fullness \_\_\_ Popping \_\_\_ Frequent Infections \_\_\_

**NOSE:** Sneezing \_\_\_ Running \_\_\_ Plugging \_\_\_ Itch \_\_\_ Mouth Breathing \_\_\_ Sinus Pressure \_\_\_

Sinus Headaches \_\_\_ Have you ever broken your nose? \_\_\_\_\_  
When? \_\_\_\_\_

**THROAT:** Soreness \_\_\_ Postnasal Drip \_\_\_ Roof of mouth itches \_\_\_ Mucus in a.m. \_\_\_

**CHEST:** Cough \_\_\_ Pain \_\_\_ Wheezing \_\_\_ Sputum \_\_\_ Shortness of breath \_\_\_

Color \_\_\_\_\_ At Rest \_\_\_  
Amount \_\_\_\_\_ On Exertion \_\_\_  
Any Blood \_\_\_\_\_

Is there any history of choking or aspiration of foreign material (such as a peanut, coin, or plastic toy going down the wind pipe)? \_\_\_\_\_ If so, please explain \_\_\_\_\_

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**SKIN:**

Inflammation \_\_\_ Eczema \_\_\_ Hives \_\_\_ Dry Skin \_\_\_ Atopic Dermatitis \_\_\_ Swelling \_\_\_ Other \_\_\_\_\_

Time of year symptoms are worse:

Year round \_\_\_\_\_

Seasonal \_\_\_\_\_ Which Season or Seasons \_\_\_\_\_

Seasonally exacerbated \_\_\_\_\_ Which Season or seasons are WORSE \_\_\_\_\_

Monthly variations (menses, workdays vs. days off) \_\_\_\_\_

Is problem usually worse at night? \_\_\_\_\_

Effect of vacation or major geographic change \_\_\_\_\_

Symptoms better indoors or outdoors? \_\_\_\_\_

What effects do weather changes have? \_\_\_\_\_

Does vigorous exercise then cooling off make you cough or wheeze? \_\_\_\_\_

Triggers: List anything that you feel makes your condition worse: \_\_\_\_\_

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Do symptoms occur around:

Old leaves \_\_\_\_\_ Hay \_\_\_\_\_ Lakeside \_\_\_\_\_ Barns \_\_\_\_\_ Summer homes \_\_\_\_\_ Damp Basement \_\_\_\_\_

Dry Attic \_\_\_\_\_ Lawn Mowing \_\_\_\_\_ Animals \_\_\_\_\_ Perfume \_\_\_\_\_ Dust \_\_\_\_\_ Plants \_\_\_\_\_ Weeds \_\_\_\_\_

Grass \_\_\_\_\_ Rain \_\_\_\_\_ Smoke \_\_\_\_\_ Cold Air \_\_\_\_\_ Newspaper \_\_\_\_\_ Fabrics \_\_\_\_\_ Dust Storms \_\_\_\_\_

Cosmetics \_\_\_\_\_ Strong smells \_\_\_\_\_ Candle Shops \_\_\_\_\_ Others (list) \_\_\_\_\_

Have you ever had a serious reaction to an insect sting or bite? \_\_\_\_\_

What type insect was it? \_\_\_\_\_ What year? \_\_\_\_\_

**PAST MEDICAL HISTORY**

Have you ever had any major illnesses or surgery? \_\_\_\_\_ If so, what and when? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any other chronic health problems? \_\_\_\_\_ What \_\_\_\_\_  
Have you ever had asthma \_\_\_\_\_ Repeated Bronchitis \_\_\_\_\_ Pneumonia \_\_\_\_\_

**FAMILY HISTORY- WHAT TYPE OF ALLERGY AND OTHER HEALTH PROBLEMS HAVE YOUR FAMILY MEMBERS HAD?**

<b>Allergies and other Health problems:</b>	<b>Is there a family history of:</b>	<b>Who?</b>
Blood Mother _____	Cystic Fibrosis _____	
Blood Father _____	Immune Deficiencies _____	
Blood Siblings _____	Severe Headaches _____	
Children _____	Pulmonary Diseases _____	
	Other Diseases _____	
Close blood relatives _____	_____	
_____	_____	

**DEVELOPMENTAL HISTORY**

During the time your mother was pregnant with you, (or you were pregnant with the patient) were there any problems? \_\_\_\_\_  
Smoking? \_\_\_\_\_  
Drink alcohol or take drugs? \_\_\_\_\_  
Any medication? \_\_\_\_\_  
Any problems at the time of delivery? \_\_\_\_\_ Birth Weight \_\_\_\_\_  
Age of the infant at the time of delivery in weeks? \_\_\_\_\_  
Any problems shortly after birth? \_\_\_\_\_  
Problems as an infant? \_\_\_\_\_  
Problems with colic? \_\_\_\_\_  
Problems with food allergies? \_\_\_\_\_  
Please indicate at which age in months the child first:  
(1) Began to walk \_\_\_\_\_  
(2) Spoke first words \_\_\_\_\_  
How are the child's school grades? \_\_\_\_\_  
Are there any significant school related problems? Yes \_\_\_\_\_ No \_\_\_\_\_ What \_\_\_\_\_  
Does the child get along with his peers? \_\_\_\_\_

**PHYSIOLOGICAL/SOCIAL HISTORY**

Where does your child stay during the day? \_\_\_\_\_ Home \_\_\_\_\_ Grandmother \_\_\_\_\_ Daycare \_\_\_\_\_ Other \_\_\_\_\_  
Any recent divorce or family disruption? \_\_\_\_\_  
New Marriage? \_\_\_\_\_  
Is anyone in your family serious ill? \_\_\_\_\_  
Any recent death in family? \_\_\_\_\_ Who? \_\_\_\_\_ When? \_\_\_\_\_  
Are there any drugs or alcohol problems in the family? \_\_\_\_\_  
Is there any significant recurrent conflict between the father & mother (husband & wife)? \_\_\_\_\_

Are you under a lot of stress? \_\_\_\_\_  
 Have you ever had a nervous breakdown? \_\_\_\_\_  
 Do you have or have you had any major recent financial problems? \_\_\_\_\_  
 Have you taken medication for your nerves? \_\_\_\_\_  
 Are things at home okay? \_\_\_\_\_  
 Do you get along well with your mate/siblings? \_\_\_\_\_  
 Do you enjoy your family? \_\_\_\_\_  
 Do you enjoy your life? \_\_\_\_\_  
 Do you suffer from depression? \_\_\_\_\_  
 Have you ever seriously considered killing yourself? \_\_\_\_\_  
 Have you been treated by a Psychiatrist? \_\_\_\_\_ When? \_\_\_\_\_ What for \_\_\_\_\_  
 Have you taken any intravenous drugs outside of legitimate medical supervision? \_\_\_\_\_  
 Have you had contact with anyone with Tuberculosis? \_\_\_\_\_  
 Do you believe that you may have been exposed to AIDS? \_\_\_\_\_  
 Do you have or have you had Hepatitis B or C? \_\_\_\_\_  
 Are you: \_\_\_\_\_ Heterosexual \_\_\_\_\_ Homosexual \_\_\_\_\_ Bisexual \_\_\_\_\_ Not sexual

**ENVIRONMENTAL HISTORY**

Where were you born? \_\_\_\_\_  
 How long have you lived in West Texas? \_\_\_\_\_  
 What type of work do you currently do? \_\_\_\_\_  
 Have you been repeatedly exposed to potent chemicals or industrial dust? \_\_\_\_\_  
 Please provide your work history with the most recent first:

EMPLOYER	INDUSTRY TYPE	JOB TASKS	START/STOP	EXPOSURES
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Were you or are you in the military? \_\_\_\_\_ What branch? \_\_\_\_\_  
 What did you do? \_\_\_\_\_ How long were you in the military? \_\_\_\_\_  
 Were you exposed to any significant chemicals? \_\_\_\_\_  
 Were you directly involved in combat? \_\_\_\_\_  
 When/where and how much? \_\_\_\_\_  
 Do you have any hobbies that involve chemicals or dust? \_\_\_\_\_ If so, what? \_\_\_\_\_  
 Does anyone smoke in the house? \_\_\_\_\_ Who? \_\_\_\_\_  
 Do you live near a factory, plant, oil well, gas well, or cotton gin? \_\_\_\_\_  
 Do you live on a farm? \_\_\_\_\_

**HOME:**

In the city \_\_\_\_\_ Rural \_\_\_\_\_  
 Type of house \_\_\_\_\_ Age of house \_\_\_\_\_  
 Apartment \_\_\_\_\_ Age \_\_\_\_\_  
 Rent house \_\_\_\_\_ Age \_\_\_\_\_  
 Has your home ever been flooded? \_\_\_\_\_ When? \_\_\_\_\_  
 Type of air conditioning \_\_\_\_\_ Central \_\_\_\_\_ Window \_\_\_\_\_ Evaporative Type of heating system \_\_\_\_\_ Central  
 \_\_\_\_\_ Wood stove \_\_\_\_\_ Open gas \_\_\_\_\_ Fire place Pets \_\_\_\_\_ Dog(s) \_\_\_\_\_ Cat(s) \_\_\_\_\_ Other \_\_\_\_\_  
 Type of stove (elec. or gas) \_\_\_\_\_  
 Do you ever see any roaches? \_\_\_\_\_  
 Do you have any mice? \_\_\_\_\_

BEDROOM	TYPE	AGE	LIVING ROOM	TYPE	AGE
Pillow _____	_____	_____	Furniture (stuffed) _____	_____	_____

Mattress \_\_\_\_\_  
Blankets (type) \_\_\_\_\_  
Furniture(stuffed, wood) \_\_\_\_\_  
Rug, Carpet, Tile, wood \_\_\_\_\_  
Stuffed toys \_\_\_\_\_  
Books \_\_\_\_\_  
Humidifier \_\_\_\_\_  
Plants \_\_\_\_\_

House Plants \_\_\_\_\_  
Artificial Plants \_\_\_\_\_  
Perfumed candles \_\_\_\_\_  
Rug, Wood, Carpet, Tile \_\_\_\_\_  
Potpourri \_\_\_\_\_  
Carpet Deodorizers \_\_\_\_\_  
Air Fresheners \_\_\_\_\_

**BATHROOM**

Mold or Mildew \_\_\_\_\_  
Carpet \_\_\_\_\_

Is there any place in the home where the symptoms are worse? \_\_\_\_\_

**ALLERGIES TO FOODS**

Do any foods seem to cause a rash, hives, eczema, swelling, make your mouth itch, nose run, give you headaches, make your stomach cramp, give you diarrhea, make you cough, or wheeze? \_\_\_\_\_ Yes \_\_\_\_\_ No

List any foods that seem to cause problems and the symptoms which you feel they cause \_\_\_\_\_  
\_\_\_\_\_

Do any of these cause problems?

Cheese \_\_\_ Mushrooms \_\_\_ Beer \_\_\_ Melons \_\_\_ Bananas \_\_\_ Fish \_\_\_ Nuts \_\_\_ Citrus \_\_\_ Fruits \_\_\_ Peanuts \_\_\_  
Eggs \_\_\_ Shellfish \_\_\_ Milk \_\_\_ Soy \_\_\_ Wheat \_\_\_ Other \_\_\_\_\_

Do you have frequent diarrhea? \_\_\_\_\_

Is there any mucus in your stool? \_\_\_\_\_

Do you have any blood in your stools? \_\_\_\_\_

Have you ever had an asthma attack shortly after eating a food? \_\_\_\_\_ Yes \_\_\_\_\_ No

What food? \_\_\_\_\_ What happens and how soon? \_\_\_\_\_

**REFLUX**

Do you wake with a sour, acid taste or metallic taste? \_\_\_\_\_

Do antacids help your problem and relieve any chest discomfort you have? \_\_\_\_\_

Do you have a hiatal hernia? \_\_\_\_\_

Do you have a lot of heartburn? \_\_\_\_\_

Do you vomit or spit up easily? \_\_\_\_\_

Does food tend to hang up in your throat when you swallow? \_\_\_\_\_

**IMMUNIZATIONS**

Are you and/or your child's immunizations up to date? \_\_\_\_\_ Yes \_\_\_\_\_ No

What is behind? \_\_\_\_\_

Have you had the Pneumonia shot \_\_\_\_\_ Pneumovax \_\_\_\_\_ Prevnar \_\_\_\_\_

Have you had a flu shot(s) this season? \_\_\_\_\_ Yes \_\_\_\_\_ No

**MEDICATIONS**

Are you allergic to any medications? (List them and state what happens) \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How long ago? \_\_\_\_\_  
 Does aspirin, yellow dyes, or sodium benzoate cause problems? \_\_\_\_\_  
 Do you take aspirin? \_\_\_\_\_ Arthritis medicine? \_\_\_\_\_  
 Do you take heart or blood pressure medications? \_\_\_\_\_  
 Do you take any thyroid medicine, or have you ever been on any? \_\_\_\_\_  
 Do you take any blood thinners? \_\_\_\_\_  
 Are you on any Beta Blockers? \_\_\_\_\_  
 Do you take eye drops? \_\_\_\_\_ What for? \_\_\_\_\_

What medicines are you currently taking? **LIST THEM ALL AND STATE WHAT THEY ARE FOR:**

<u>Drug</u>	<u>Reason for Drug</u>	<u>Doctor who prescribed it</u>
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		
10. _____		
11. _____		
12. _____		

Are you taking any herbs, vitamins or alternative medicines? List them and what they are for:  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you had previous allergic treatment or testing? \_\_\_\_\_ Dr. \_\_\_\_\_  
 When? \_\_\_\_\_  
 What type of treatment? \_\_\_\_\_ Did it help? \_\_\_\_\_

**PHYSICAL AGENTS AND HABITS**

Tobacco use for \_\_\_\_\_ years.  
 Cigarettes \_\_\_\_\_ packs per day.  
 Chewing tobacco or snuff amount per day \_\_\_\_\_ Cigars \_\_\_\_\_ per day.  
 Pipe Bowls \_\_\_\_\_ per day.  
 Cans of beer \_\_\_\_\_ per day. Circle light or regular: 12 oz., 16 oz., 20 oz.  
 Alcoholic drinks \_\_\_\_\_ per day.  
 Glasses of wine (6 oz) \_\_\_\_\_ per day.  
 Do you smoke marijuana? \_\_\_\_\_ Joints per day? \_\_\_\_\_  
 Do you take non-prescribed pills or inject any non-prescribed drugs? \_\_\_\_\_  
 Have you had drug or alcohol problems in the past? \_\_\_\_\_  
 Do you take sleeping pills or pain killers on a regular basis? \_\_\_\_\_  
 Do you do any regular exercise? \_\_\_\_\_ What type \_\_\_\_\_  
 How often? \_\_\_\_\_ How long at a time \_\_\_\_\_ minutes

**REVIEW OF SYSTEMS**

Do you have or have you ever had thyroid disease? Yes \_\_\_\_\_ No \_\_\_\_\_

\_\_\_\_\_ Hypo \_\_\_\_\_ Hyper \_\_\_\_\_ Goiter \_\_\_\_\_ Cancer  
 Do you have heart problems? \_\_\_\_\_ Yes \_\_\_\_\_ No What type? \_\_\_\_\_  
 \_\_\_\_\_ Beats irregularly \_\_\_\_\_ Missed Beats \_\_\_\_\_ Chest/heart Pain \_\_\_\_\_ Murmur \_\_\_\_\_ MI  
 Blood Pressure Problems? \_\_\_\_\_  
 Have you ever had a heart attack? \_\_\_\_\_  
 Do you have problems with your blood? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 \_\_\_\_\_ Leukemia \_\_\_\_\_ Anemia \_\_\_\_\_ Clotting problems  
 Have you ever had a stroke? \_\_\_\_\_  
 \_\_\_\_\_ Kidney Problems \_\_\_\_\_ Prostate \_\_\_\_\_ Bladder  
 Do you have diabetes? \_\_\_\_\_  
 Have you ever had cancer? \_\_\_\_\_ If so, type \_\_\_\_\_  
 Do you have significant problems with your eyes? \_\_\_\_\_  
 Have you had increased eye pressure (glaucoma)? \_\_\_\_\_  
 Have you ever had a seizure? \_\_\_\_\_  
 Have you ever had any significant head trauma? \_\_\_\_\_  
 If so, what and when? \_\_\_\_\_  
 Do you have sick headaches (migraines)? \_\_\_\_\_  
 Do you have any recurrent headaches that wake you out of sleep? \_\_\_\_\_  
 Do you have any neurological/nervous system problems? \_\_\_\_\_  
 Do you have any problems with your stomach or GI tract? \_\_\_\_\_  
 Have you had unexpected weight gain or loss? \_\_\_\_\_  
 Do you have any significant male or female problems? \_\_\_\_\_  
 Do you get abnormally short of breath when you exercise? \_\_\_\_\_  
 Do you develop chest pain and difficulty breathing when you exercise? \_\_\_\_\_  
 Have you been exposed to Tuberculosis? \_\_\_\_\_  
 Do you have any pulmonary/lung problems not covered above? \_\_\_\_\_  
 Have you had night sweats or unusual fever? \_\_\_\_\_  
 Do you have significant arthritis? \_\_\_\_\_ Rheumatological problems? \_\_\_\_\_  
 What type? \_\_\_\_\_  
 Do you have any other significant muscle, bone or joint problems? \_\_\_\_\_  
 Do you have any skin problems not covered above? \_\_\_\_\_  
 Have you noticed any enlargement of any of your lymph nodes? \_\_\_\_\_ Yes \_\_\_\_\_ No  
 Where \_\_\_\_\_  
 Women: Are you pregnant? \_\_\_\_\_ When was your last menstrual period? \_\_\_\_\_

## **SLEEP QUESTIONS**

Do you have any of the following problems?

1. Do you snore loudly or frequently? \_\_\_\_\_
2. Do you breathe irregularly or stop breathing during your sleep? \_\_\_\_\_
3. Are you tired and sleep during the day? \_\_\_\_\_
4. Do you have a hard time falling asleep? \_\_\_\_\_
5. Do you wake up in the early morning hours when you want to sleep? \_\_\_\_\_
6. With emotional situations, such as laughing, do you become weak and fall down? \_\_\_\_\_
7. Do you nap? \_\_\_\_\_
8. How many hours a day do you sleep? \_\_\_\_\_
9. Do you wake up gasping for air? \_\_\_\_\_
10. Do you sleep with your mouth open? \_\_\_\_\_
11. Do you sleep with your neck cocked back? \_\_\_\_\_
12. Are you a very restless sleeper? \_\_\_\_\_
13. Do your legs creep, crawl, or jump around when you try to sleep? \_\_\_\_\_
14. Do you have problems staying awake when you drive? \_\_\_\_\_
15. Does anyone else in your immediate family have any of those problems? \_\_\_\_\_ Who? \_\_\_\_\_

Is there any other information about you or your medical history that you think is important? \_\_\_\_\_

\_\_\_\_\_

Do you have a primary physician that looks after you or your child's health? \_\_\_\_\_

Please list his/her name, address, and telephone number.

\_\_\_\_\_

\_\_\_\_\_

Please list the name of the person who referred you and their address.

\_\_\_\_\_

\_\_\_\_\_

**THANK YOU FOR BEING THOROUGH IN FILLING OUT THIS DETAILED, ALLERGY IMMUNOLOGY PULMONARY MEDICAL HISTORY. OBTAINING A GOOD MEDICAL HISTORY IS FAR AND AWAY THE MOST IMPORTANT THING THAT A PHYSICIAN CAN DO TO MAKE A PROPER DIAGNOSIS. EVERYTHING THAT FOLLOWS IN YOUR CARE DEPENDS ON ITS QUALITY.**