allergy associates research center

6327 SE Milwaukie Avenue, 2nd Floor
Portland OR 97202

Date of Completion: _____

Name: Last_____ First_____ M.I._____ Date of Birth:_____

Please check corresponding Race and Ethnicity as applicable:

Race: Caucasian_____ Black_____ Asian_____ Other (specify)_____

Ethnicity: Hispanic _____ Non-Hispanic _____

Please include ALL YOUR CURRENT or PAST HEALTH PROBLEMS and APPROXIMATE DATE OF DIAGNOSIS.

RESPIRATORY

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Asthma			
COPD/ Emphysema/ Chronic Bronchitis			
Pneumonia			
Collapsed Lung			
Sleep Apnea			
Positive TB Test (Chest X-Ray +/-)			
Other			

ALLERGIC

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Seasonal Allergic Rhinitis			
Perennial Allergic Rhinitis (Year Round)			
Drug Allergies			
Food Allergies			
Other			

HEMATOLOGICAL (BLOOD)

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Anemia			
Clotting/Bleeding Disorder			
Blood Transfusion			
HIV Infection/AIDS			
Leukemia			
Other			

EYES, EARS, NOSE, THROAT

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Nasal Polyps			
Deviated Nasal Septum			
Sinusitis			
Hearing Loss (R and/or L)			
Hearing Aid (R and/or L)			
Edentulous (Wears Dentures)			
Myopia (Nearsighted)			
Hyperopia (Farsighted)			
Astigmatism			
Lasik Surgery (R and/or L)			
Cataracts (R and/or L)			
Glaucoma (R and/or L)			
Other			

HEPATIC (LIVER)

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Hepatitis A, B, and/or C			
Cirrhosis (Liver Disease)			
Pancreatitis			
Other			

SKIN

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Significant Acne			
Psoriasis			
Hives			
Eczema (Atopic Dermatitis)			
Rosacea			
Shingles			
Non-Cancerous Cyst/Tumor			
Other			

RENAL (KIDNEY) / URINARY

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Kidney Stones			
Recurrent Urinary Tract or Kidney Infections			
Painful Urination			
Blood in Urine			
Overactive Bladder			
Urinary Incontinence			
Other			

MUSCULOSKELETAL

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Osteoarthritis (specify location)_____			
Rheumatic Fever			
Rheumatoid Arthritis (specify location)_____			
Back Injury			
Recurrent joint Pain (specify location)_____			
Fibromyalgia			
Recurrent Tendonitis (specify location)_____			
Gout			
Chronic Fatigue Syndrome			
Osteoporosis			
Other			

CARDIOVASCULAR

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
MI (Heart Attack)			
Angina (Chest Pain)			
Hypertension (High Blood Pressure)			
High Cholesterol			
CVA (Stroke)			
TIA (Mini-Stroke)			
Arrhythmia (Irregular Beat)			
Heart Murmur			
Congestive Heart Failure			
Peripheral Vascular Disease			
Other			

ENDOCRINE

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Type I Diabetes (Juvenile)			
Type II Diabetes (Adult)			
Hypothyroidism (Underactive Thyroid)			
Hyperthyroidism (Overactive Thyroid)			

GASTROINTESTINAL

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Stomach Ulcer			
Gallstones			
Irritable Bowel Syndrome			
Recurrent Diarrhea			
Reflux (GERD)			
Heartburn			
Erosive Esophagitis			
Hernia (specify)_____			
Hemorrhoids			
Colon Polyps			
Treated for H pylori			
Crohn's Disease			
Other			

PSYCHIATRIC

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Depression			
Insomnia			
Bipolar Disorder			
Schizophrenia			
Anxiety Disorder			
OCD (Obsessive Compulsive Disorder)			
Panic Disorder			
ADD or ADHD (circle)			
Other			

NEUROLOGICAL

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Epilepsy (Seizure Disorder)			
Carpal Tunnel (R and/or L)			
Headaches (Sinus/Tension)			
Migraines			
Parkinson's Disease			
Multiple Sclerosis			
Neuropathy (Numbness/Pain In Extremities)			
Other			

GENITAL (Males Only)

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Prostatitis (Prostate Infection)			
BPH (Enlarged Prostate)			
Sexually Transmitted Diseases (specify) _____			
Vasectomy			
Other			

GENITAL (Females Only)

CONDITION	ONSET DATE	DATE RESOLVED	COMMENTS
Irregular Periods			
Painful Periods			
Heavy Periods			
Ovaries Removed			
Endometriosis			
Uterine Fibroids			
Ovarian Cyst			
Sexually Transmitted Diseases (specify) _____			
Other			

CHILDBEARING POTENTIAL (Females Only)

Are you of childbearing potential (circle one)? YES NO

If yes, complete the following:

Contraceptive Measures (check all that apply)			
	Double Barrier Method		Oral Contraceptive
	Injectable		Diaphragm
	Intrauterine Device (IUD)		Patch/Cervical Ring
	Vasectomized Partner		Abstinence

If no, complete the following:

Reason		Date
	Hysterectomy	
	Tubal Ligation (tubes tied)	
	Post Menopausal (last cycle date)	
	Premenarchal (Prepubescent)	

SURGERY/ HOSPITALIZATION

CONDITION/REASON	DATE	COMPLICATIONS

CANCER

CANCER TYPE	DIAGNOSIS DATE	DATE RESOLVED	COMMENTS

FAMILY HISTORY

(Check all that apply)

CONDITION	FATHER	MOTHER	SIBLINGS	OFFSPRING	OTHER
Asthma					
Allergic Rhinitis					

ALCOHOL AND TOBACCO USE

What is your average alcohol consumption per week? _____ ☐ None

Are you a current or former smoker? **YES*** **NO**

*If yes, Start date: _____ Stop date: _____ OR ☐ Ongoing

Type of tobacco use (circle): Cigarettes Cigars Pipe E-Cigarettes Chewing Tobacco

Average amount per day: _____ Pack year calculation: _____
(To be completed by staff)

Do you have a history of ANY drug or alcohol abuse/addiction? **YES*** **NO**

*If yes, Start date: _____ Sobriety date: _____ OR ☐ Ongoing

Substance of abuse: _____

Did you or are you currently receive treatment for Recovery/Sobriety (circle): YES* NO

*If YES, please explain_____

MEDICATIONS

Medications: Please list all medications you currently take, or take on a regular basis. This includes over-the-counter medications, including alternative/herbal and prescription medications. Please include medications you take on an as needed basis such as Tylenol for headaches or Tums for indigestion. List all medications taken in the past 6 months and medications you may take during the study.

EXAMPLES OF HOW TO LIST MEDICATIONS

Medication	Dose	Frequency	Route	Start Date	Stop Date or Continued	Reason for taking medication
Tylenol	*500 mg*	*As needed*	*Orally*	*1/1980*	*Cont.*	*Occasional headaches*
Albuterol	*2 puffs*	*2 x day*	*Inhaled*	*6/1990*	*Cont.*	*Asthma*
Vicodin	*1 tab*	*As needed*	*Orally*	8/25/00	*Cont.*	*Back pain*

Please include all Prescriptions, over-the-counter, and alternative/herbal medications.

Medication	Dose	Frequency	Route	Start Date	Stop Date or Continued	Reason for taking medication

By signing below, I certify that this history provided is accurate to the best of my knowledge.

Patient Signature:_____ Date:_____

Interviewer Signature:_____ Date:_____

For Office Use Only

VITAL SIGNS

Date Performed	Time Performed (24 hour clock)	Blood Pressure *(mmHg)* ❒ Right Arm ❒ Left Arm	Pulse (*beats/min)*

If any abnormal values have PI assess patient safety

WEIGHT & HEIGHT

*Taken **without shoes***

Height (cm)	Weight (kg)	BMI

Additional notes/comments: