Santiago Martinez, M.D., P.A.

DIPLOMATE OF THE AMERICAN BOARD OF ALLERGY AND IMMUNOLOGY

733 South Goldenrod Road, Suite A
Orlando Florida, 32822
TEL: (407) 672-0060
Fax: (407) 672-0440

NTC Sports Medicine Institute
1925 Don Wickham Drive., Suite 115
Clermont, Florida 34711
Phone: (352) 242-3791

Date_________________________

PATIENT HISTORY CHART

Name___________________________ ☐ Male Female ☐ Date of Birth _______________________
Address___________________________________ Home Telephone: ___________________________
___________________________________ Work Telephone:_____________________________
Age ____________☐ Married ☐ Single ☐ Divorced Employer_______________________________
Referred by__________________________ Social security No. ______________________________

I. CHIEF COMPLAINT- **Reserved for Doctor/Staff only**

CC:____

History of Present illness:

HPI: ______Month(s)______ year(s) old ☐ Male ☐ Female with:
_________Days _________Weeks _________Months _________ Years **History of nasal symptoms:** ☐ None
☐ Snoring ☐ Runny nose ☐ Sneezing ☐ Nasal congestion ☐ Nasal itching ☐ Watery itchy eyes
☐ Post nasal drip ☐ Perennial ☐ Seasonal (during : ___ Winter ___ Spring ___Summer ___Fall)
Recurring sinusitis: ☐ None for ______Years occurring ______ per year.
Recurrent Otitis media: ☐ None _______per year ____
Recurrent Pneumonia: ☐ None _______per year ____
Recurrent Bronchitis: ☐ None _______per year ____
________Days _______Weeks _______Months _______ Years **History of asthma:** ☐ None
Diagnosed by: Dr.________________________
Asthma symptoms consist of: ☐ Wheezing ☐ Coughing ☐ Chest tightness ☐ SOB Asthma symptoms occur _______ per week ______ per month _______ per year.
Nocturnal asthma: ☐ None ☐ Yes, occurring ______per week, _____ per month
_______Days _______Weeks _______Months _______ Years **History of Eczema or Skin rash:** ☐ None
Diagnosed by Dr.__________________________ Pruritic ☐Yes, ☐ No
involving ____
☐ Cheeks ☐ Flexural areas (Popliteal / Antecubital)_____________________________________
Presently treated with: ____
Patient has responded ☐ Yes, ☐ No to the following
medication____
____
________Days _______Weeks _______Months _______ Years **History of Urticaria (Hives)**: ☐ None
occurring ____
Pruritic ☐Yes, ☐ No. Involving ____
____
Lasting < or > 24hrs. Resolve leaving skin intact ☐ Yes, ☐ No ______________________________
Associated with ____
Hives have responded ☐ Yes, ☐No to the following medications _______________________________
____

Reviewed with patient_____

Reviewed with patient_____

II. REVIEW OF SYSTEMS:

Constitutional Symptoms: □ Negative /____

Eye/Ear/Nose and Throat: □ Negative / Loss of vision, blurry vision, cataracts, glaucoma, loss of hearing, itching in ear, ringing in the ears, loss of balance, loss of sense of smell, loss of sense of taste, excessive tearing, dry eyes, itchy eyes, conjunctivitis, ear infections, dry mouth, postnasal drainage. ____

Pulmonary: □ Negative ____

Heart: □ Negative / Chest pain, palpitations, swelling of ankles, inability to lie flat in bed. Hypertension____

Intestinal tract: □ Negative/ Nausea, vomiting, heartburn, indigestion, trouble swallowing liquids or food, abdominal pain, constipation, diarrhea, excessive gas, food intolerances, gallstones, acid or sour taste in mouth, blood in stool. ____

Reproductive/urinary: □ Negative/ Irregular periods, skipped periods, unusual Vaginal bleeding, menopause, infertility, miscarriages, impotence, unplanned pregnancy, planned pregnancy. Kidney stone, inability to urinate, prostate problems, kidney infections.

Lymph glands/HEM: □ Negative/ Glandular swelling, glandular tenderness.______________________________

Endocrine: □ Negative / Hypo /Hyper thyroidism, D.M, Other______________________________

Infectious: □ Negative/Recurring sinusitis, recurring O.M, recurring pneumonia, recurring bronchitis and **Other**____

Rheumatologic & Orthopedic: □ Negative / Early morning joint stiffness, joint swelling, joint pain, gout, low back pain, osteoporosis, fractured bone. ____

Skin: □ Negative / Skin rash, hives, eczema, skin tumors or growths, excessive hair loss.

Neurologic/Psychiatric: □ Negative / Fainting spells, severe headaches, epilepsy (seizures), difficulty with memory, inability to Concentrate, other______________________________

III. PAST MEDICAL HISTORY:

Hospitalizations:____

ER Visits: ____

Medical____

Surgeries:____

Adverse food Reactions: ____

Adverse Drug Reactions:____

Latex Sensitivity:____

Insect Sting:____

Immunization Status:____

Reviewed with patient_____

IV. FAMILY HISTORY

	ASTHMA	HAY FEVER	ECZEMA	HIVES	SINUSITIS	OTHER
Father						
Mother						
Siblings						
Grandparents (Maternal)						
Grandparents (Paternal)						
Aunts/Uncles (Maternal)						
Aunts/Uncles (Paternal)						

V. PAST ALLERGY THERAPY/TESTING:

Immunotherapy: ____

____

Drugs: ____

____

____

VI. SOCIAL HISTORY:

Marital Status: ______________________ Education:______________________

Current occupation:______________________ Hobby: ______________________

Geography:____

Smoking: Current ______________ Past ________________ Secondary _________________

Drug/Alcohol use: ____

ENVIRONMENTAL: (Check one or more if applicable)

DWELLING: ☐ Apartment ☐ Private Home ☐ Mobile Home

☐ Rural ☐ City

Age of House?______________ How long has patient lived in the house?________________________

Fans ☐ Yes ☐ No

Air conditioning ☐ Central ☐ Wall ☐ Window

Heating system ☐ Gas ☐ Electric ☐ Coal ☐ Other

Type of Filter ☐ Disposable ☐ Reusable

Reviewed with patient_____

Frequency of Change:	☐ Monthly	☐ Yearly		
Humidifiers:	☐ Yes	☐ No		
Pets:____				
Type of Pillows	☐ Foam	☐ Feather		
Indoor Plants:	☐ Yes	☐ No		
Area of dampness, Mold Mildew:	☐Yes	☐ No		
Plastic Zippered covers on Pillows, Mattresses, Box spring:			☐ Yes	☐ No
Carpet:	☐ Yes	☐ No		
☐ Venetian Blinds	☐ Drapes	☐ Window Shades		

VII. OTHER CURRENT MEDICATIONS:

1)______________________________ 6) ______________________________

2) ______________________________ 7) ______________________________

3) ______________________________ 8) ______________________________

4) ______________________________ 9) ______________________________

5) ______________________________ 10) ______________________________

VIII. CIRCLE WHAT MAKES SYMPTOMS WORSE

FOODS	DRUGS	ASPIRIN
INDOORS	OUTDOORS	EXERCISE
EMOTIONAL UPSET	COLD AIR	INFECTIONS (COLDS)
CUT GRASS	RAKED LEAVES	DOG/CAT
OTHER ANIMALS_________	SMOKE	DAMPNESS
CHANGE IN WEATHER	AIR CONDITIONING	DUSTING
COSMETICS	OTHER:______________________________	

Reviewed with patient_____

IX. PHYSICAL EXAM

P ________ *RR*___________ *Peak Flow*________ *Temp*__________ *BP*_____________ *WT*_________ *HT*_________

***PHYSICAL EXAM*:** **General Appearance:** ____

Eyes: (Conj/Lid) WNL ☐ Allergic Shiners ☐ Eye discharge ☐ Redness ☐ Not examined ☐
Ears: WNL ☐ Hyperemic/Dull/Fluid/TM L/R ☐ Ear tubes ☐ Not examined ☐
Nose: WNL ☐ Swollen Turbinates ☐ Pale looking mucosa ☐ Polyps L/R ☐ Allergic Crease ☐ Nasal Flaring ☐
Septum WNL ☐ Deviated ☐
Nasal Discharge: None ☐ Clear ☐ Yellow ☐ Green ☐ Freq:_________________
Sinus Tenderness: Negative ☐ Maxillary: L ☐ / R ☐ Bilateral ☐ Frontal ☐
Lungs - Air exchange: Good ☐ Poor ☐ Cough ☐ Wheezing: Inspiratory ☐ Expiratory ☐ Bilateral ☐
Mild ☐ Moderate ☐ Severe ☐ Rales ☐ Rubs ☐ Rhonchi ☐
Oropharyx: WNL ☐ Cobblestoning mucosa ☐ Post nasal drip ☐ **Skin:** Normal ☐ Hives ☐ Eczema ☐
CVS: (Sounds/M) Normal ☐ Abnormal ☐ murmurs ☐ Not Examined ☐ ______________________________________
Neck: Supple ☐ No Adenopathy ☐ Adenopathy ☐ Not Examined ☐ ____
Neuro/Psych: _______________________ **ABD:** _________________________________ Deferred ☐ **Other:** ________________ ___

LABS ORDERED:

- ☐ **CBC w/dif IgE, IgG, IgA, IgM, IgG_1, IgG_2, IgG_3, IgG_4**
- ☐ **CBC w/dif IgE, IgG, IgA, IgM, IgG_1, IgG_2, IgG_3, IgG_4 T and B cell subsets, mitogens to CON-A, PHA, Pokeweed**
- ☐ **Diphtheria and Tetanus titers RAST to Dust Mites (DP,DF) Cat, Dog, Alternaria, Penicillium, Cladosporium, Aspergillus, Bahia, Bermuda, Ragweed, Oak, Cockroaches, and Other:________**
- ☐ **Total IgE**
- ☐ **CBC w/diff, IgE**
- ☐ **Complete Metabolic Panel**
- ☐ **C_3, C_4, CH_{50}, ANA**
- ☐ **C_1 esterase inhibitor**
- ☐ **U/A**
- ☐ **Thyroid microsomal and thyroglobulin antibodies**
- ☐ **SSA, SSB**
- ☐ **Ds DNA**
- ☐ **Rheumatoid factor**
- ☐ **PULMONARY FUNCTION TEST pre/post, DLCO and FLOW VOLUME LOOP. Please send interpretation.**
- ☐ **CHEST X-RAY**
- ☐ **SWEAT TEST (Quantitative)**
- ☐ **CT OF THE SINUS WITHOUT CONTRAT**

FEV_1:_____________________ **Interpretation**:____
FVC:_____________________ ____
FEF 25-75%_________________ ____

DIAGNOSIS: _____**Bronchial Asthma** ____**Allergic Rhinitis** ____**Chronic Rhinitis** ____**Polyps** _____**Acute Sinusitis**
____**Cough** _____**COPD** ____**Headache** ____**Uticaria** ____**GER** ____**Recurrent OM** ____**Adenoidal Hypertrophy**
____**Conjunctivitis** ____**Immune Deficiency** ____**Eczema** **Other:**_________________________________

____
____
____
____

PLAN: RTC____________ Weeks_____________Months
____Environmental Control Measures reviewed ______ Literature Given ______ Pet Removal
____Advised on use of Hepa Filters ______Cigarette Smoking Avoidance
Medications:____
____

Immunotherapy: Indicated_____ Not Indicated______Observe______Patient prefers alternative therapy___________

Other Plan:____