ALLERGY AND ASTHMA SPECIALISTS OF CADILLAC



MARTIN DUBRAVEC, MD

THE HISTORIC MITCHELL HOUSE

200 East Mason Street • Cadillac, MI 49601

PH: (231) 779-4444 • FAX: (231) 779-2859

Patients - please fill out this side:

1 atlents - please im out th	is siuc.
What brings you to see us?	
Sneezing, itchy, runny nose	yes
no	
Nasal congestion	yes I
no Postnasal drip, throat clearing	yes I
no	a yes a
Frequent coughing	yes •
no	•
Itchy, watery eyes	yes
no	
Frequent yellow/green nasal	yes
no drainage	
Recurrent sinus infections	yes •
no	-
Decreased sense of smell	yes •
no	
No sense of smell	yes •
no D	
Recurrent ear infections	yes
no Frequent headache	yes I
no	5 yes 5
Wheezing	yes
no	• -
Shortness of breath	yes •
no	
Skin rash	yes
no Hives/swelling	yes •
no	- yes -
Possible reaction to a bee sting	yes
no	• -
Possible reaction to a food	yes
no	
Your symptoms occur	5 .
In the spring summer fall all of the time indoors out	
at work at school	u0018
at work at solitor	
Triagona of vove	
Triggers of your symptoms: cats dogs dust molds	mowing
lawns smoke cold air cold	
temperature changes emotio	-
other:	

	BirthdateToday's Date		
	Referring HCP		_
			_
			_
			_
			_
			_
			_
			_
			_
			_
На	ave these medications been prescribed? Date?	Hel	pful?
	Claritin (loratadine)	_ 🗆 Y	\square N
	Zyrtec (cetirizine)	_ 🗆 Y	\square N
		- X7	\square N
	Allegra (fexofenidine)		
	Allegra (fexofenidine) Flonase (fluticasone)		\square N
Pr	Flonase (fluticasone)ior Allergy Work-up:		
Pr Si	Flonase (fluticasone)		
Pr Si	Flonase (fluticasone) ior Allergy Work-up: nus CT XR	_	□ N
Pr Si CZ Sk Pr	Flonase (fluticasone) ior Allergy Work-up: nus CT	_	□ N
Pr Si CZ Sk Pr	Flonase (fluticasone) ior Allergy Work-up: nus CT XR xin Tests Date_ ior allergy shots helped not helped reactions nus Surgery Date_	_ □ Y	□ N
Pr Si CZ Sk Pr	Flonase (fluticasone) ior Allergy Work-up: nus CT XR xin Tests Date_ ior allergy shots □ helped □ not helped reactions	_ □ Y	□ N
Pr Si CZ Sk Pr	Flonase (fluticasone) ior Allergy Work-up: nus CT XR xin Tests Date_ ior allergy shots helped not helped reactions nus Surgery Date_	_ □ Y	□ N

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Patients - please fill out this side:

Please list all of y	your medication	ns:
Medication	How much	How often
		
	lergy or asthma	treatment you have
had in the past:	helned	d? ■ yes ■ no
		d? yes no
	helped	d? ■ yes ■ no
	helped	d?∎ yes ■ no
Other Medical Pr	oblems	
o ther medical ri		
Past Surgeries: _		
D1 1 1 1 0		
	ou have had the in the past year	ese immunizations:
Pneur)
Please list any mo	edical problems	s in your family:
Mother		
Father		
Brother(s)		
Sister(s)		
i our child(ren)_		
Aunt(s)/Uncle(s)		
Cousins		

Nan	ne:		
Date	e:		
hysic	cian Notes	:	

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Patients - please fill out this side:

rationts please in out this side.
Social History Primary residence is: ■ home ■ apartment Approximate age of dwelling years old Do you use tobacco? ■ yes — number of packs per day ■ no ■ 2 nd hand exposure chewing tobacco □ yes □ no Are your symptoms worse outside your home? ■ yes ■ no Hobbies:
Current Environmental Exposures
Current Environmental Exposures Current Environmental Exposures Pets at home: acat(s) dog(s) bird(s) hamster gerbil guinea pig other
Pets are indoor outdoor both Your heating: forced air radiator wood burning stove or fireplace Your basement is musty dry moldy Do you spend much time in the basement? yes no Type of bed: mattress/boxspring waterbed air mattress other Do you have dust mite encasings on your mattress/pillows? yes no Are stuffed animals in the bedroom? yes no If you have houseplants, where are they located?
Review of Systems Fever Weight loss Skin problems (besides eczema or hives) Joint swelling or pain Blood count problems Eye problems/ contacts wearer Throat infections Heart problems High blood pressure Upset stomach/nausea/vomiting Heartburn/ulcer disease Urinary or bladder problems Nerve or psychiatric problems Hormonal problems Possible pregnancy Other

Physician Notes:	