

ALLERGY ASTHMA SPECIALISTS, P.A.
ALLERGY HISTORY

Patient to Complete: Patient Name _____ DOB: _____
Today's Date: _____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS: circle

Do you have or ever had: Heart disease High blood pressure Asthma Bronchitis Pneumonia
 Sinus Infections Recurrent ear problems Connective tissue disease. Arthritis
 Gastrointestinal disease GYN problems Glaucoma Cataracts Seizures Intellectual Challenge
 Developmental delay Learning problem Thyroid problem Cancer: what kind _____ treatment _____
Other medical problems (please list) _____

List ALL previous hospitalizations and surgeries _____

FAMILY HISTORY: Asthma. Cystic Fibrosis. Emphysema. Allergic rhinitis (hay fever)
 Recurrent infection Bronchitis Sinus infections Tuberculosis Hives Thyroid disease

ENVIRONMENTAL HISTORY: Describe your environment

Work/School: old new recent remodeling. leaks mildew dusty chemicals exposure
Home: old how old ____ new Recent remodeling leaks mildew dusty hobbies: _____
Bedroom: carpeted heavy draperies stuffed animals central air
Pets: dogs cats birds other _____ indoor outdoors For how many years? _____
Do you have any hobbies involving: paints fumes fragrances other chemical substances

What is your occupation? _____

SOCIAL HISTORY: circle

Currently Smoking: Yes No Ex-smoker-stopped ____ years ago Exposure to smoke
Alcohol use: Yes No occasionally/socially. Substance abuse: Yes No HIV/AIDS Yes No

Other Questions: Very Important to answer

Have you ever been evaluated for allergy symptoms? Yes No
Have you had previous skin testing for allergies? Yes No When? _____
Have you ever taken allergy injections? Yes No When was the last injection? _____
Have you ever been hospitalized for this problem? Yes No Where? _____
Have you had blood work done recently? Yes No What tests? _____
Have you received Intravenous Infusion of Immunoglobulin/**SUB Q** Yes No

Do you get desensitization shots for insects? Yes No Which ones? _____

ALLERGIES TO MEDICATIONS: Yes. No List _____

Kind of symptoms from the medication allergies? Breathing difficulty. Hives. **Rash.** Stomach irritation

ALLERGIES TO INSECTS: Yes No List _____

Kind of symptoms from it? Breathing difficulty Hives. rash

ALLERGIES TO FOODS: Yes No List _____

Kind of symptoms from it? Breathing difficulty. Hives. Rash. Stomach irritation Bloating.

ALLERGIES TO LATEX: Yes. No List _____

Kind of symptoms from it? Breathing difficulty Hives Rash.

CURRENT MEDICATIONS: (please include **over the counter, alternative, vitamins and herbal medicines**)

PRIOR ALLERGY AND OR ASTHMA MEDICATIONS: (include nasal spray and inhalers)

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PATIENTS TO COMPLETE THIS FORM PRIOR TO OFFICE VISIT Date of office visit: _____

Patient's Name _____ DOB: _____ Age _____ Race _____

Primary Care Doctor: _____ Phone # _____ Referring Doctor _____
(First and last name)

Symptoms for which you want to see Allergy Asthma Specialists:

1. _____ Length (duration) of symptoms _____
2. _____ Length (duration) of symptoms _____
_____ Length (duration) of symptoms _____

MEDICAL HISTORY: Please Mark any of the symptoms you have had in the past 12 months or longer

General: Frequent colds Fatigue Tiredness Irritable Difficulty sleeping

Please Mark any of the symptoms you have had in the past 12 months or longer

Nasal symptoms: Runny Itchy Stuffy Sneezing Dry For how long? _____ **Symptoms present:** All year
 On and off Spring Summer Fall Around dust/vacuuuming Animals Freshly cut grass/mowing lawn Cigarette smoke
 Wood burning smoke Season change other _____ **Mucus color:** Clear Yellow Green Bloody Dry
 Frequent sinus infections. How many in past 12 months _____ Decreased sense of smell Decrease sense of taste
 Mouth breather Snoring Sleep Study _____

Eyes Symptoms: Mark all that apply:

Itchy Watery Red Dry Sore Dark circles under the eyes Eyelid swelling

Ear symptoms

Decreased hearing Hearing test _____ Fullness/clogged Popping Frequent infections Drainage Itchy Dry
 History of ear tubes Number of sets _____

Throat symptoms

Sore Scratchy Itchy Hoarseness Bad breath Throat clearing Post nasal drainage Recurrent infections
 Strep throat Lump in the throat

Headaches

Facial pain Sinus pain Frequency _____ week / month. Location of pain _____ Light sensitivity
 Noise sensitivity History of migraine headaches

Skin symptoms

Rash: date started? _____ Welts Itchy Dry Scaly Eczema, age at which it started _____ Rash caused by
(List them) _____ Insect bite Food Drug reaction _____ Other _____

Abdomen/Stomach: Mark all that apply:

Nausea Vomiting Stomach upset Epigastric discomfort Bloating Gas Heartburn (food or liquid to throat area)

Lungs or Chest symptoms

Cough Dry Productive **Mucus color:** White Yellow Green Blood tinged Chest tightness Short of breath

Wheezing with: Breathing in Breathing out Exercise Laying down

Symptoms increases with: Cold weather Infections Laughing Emotions/crying Nighttime Cigarette smoke

Wood burning smoke Exercise Other _____

Female Patients Only: Are you pregnant? Yes No Last Menstrual Cycle _____ / _____ / _____

ABSENTEISM: Number of days missed from school or work in last 12 months because of the above problems _____

Reviewed/Exam BY: _____