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ALLERGY ASTHMA SPECIALISTS
ALLERGY HISTORY

Patient Name _____ **Date** _____

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS:

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

_____ List ALL previous hospitalizations and surgeries _____

FAMILY HISTORY of: Asthma. Cystic Fibrosis. Emphysema. Allergic rhinitis (hay fever)

Recurrent infection Bronchitis Sinus infections Tuberculosis Hives

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/furniture . central air. Feather pillow feather bed. Feather comforter.

Pets: dogs' cats bird. 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:

Currently Smoking: Yes. No ex-smoker-stopped ____ years ago exposure to smoke

Alcohol use: yes no. occasionally/socially. Substance abuse: Yes. No. HIV positive: Yes No.

AIDS: Yes. No

Other:

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? 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. Breathing difficulty. Hives. rash

ALLERGIES TO FOODS: Yes No List _____

Kind of symptoms from it? Breathing difficulty. Breathing difficulty. Hives. Rash. stomach irritation.
 bloating.

ALLERGIES TO LATEX: Yes. No List _____

Kind of symptoms from it? Breathing difficulty. Breathing difficulty. Hives. Rash.

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

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____