

ALLERGY ASTHMA SPECIALISTS, P.A.
ALLERGY HISTORY

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

PAST MEDICAL HISTORY/REVIEW OF SYSTEMS:

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 Mental retardation
 Developmental delay Learning problem Thyroid problem Cancer: what kind _____ treatment _____
Other medical problems (please 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 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:

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:

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 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)
