☻ ☻

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 □ 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: □ 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:
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.□ **r**ash
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)

_____ _____ _____

Reviewed/Exam BY: _____

☻ ☻

ALLERGY ASTHMA SPECIALISTS, P.A.
ALLERGY HISTORY

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 _____
3. _____ Length (duration) of symptoms _____

MEDICAL HISTORY: Please **CIRCLE** any of the symptoms you have had in the past 12 months or longer
General: □ Frequent colds □ Fatigue □ Tiredness □ Irritable □ Difficulty sleeping

Nasal symptoms: □ Runny □ Itchy □ Stuffy □Sneezing □ Dry For how long? _____ **Symptoms present**: □ All year □On and off □Spring □Summer □ Fall □Around dust/vacuuming □ 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: circle
□ 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: circle
□ 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: _____