WELCOME to Our Allergy and Asthma Evaluation Center

If you are new to our practice, please help us to get a head start by completing the information below. If you have been seen in the last **six** months, you only need to indicate any changes since your last visit.

PATIENT NAME: ______________________________ **DATE:** ______________

PLEASE MARK ALL THAT APPLY:

Constitutional:	Headache	Fever	Weight Loss		
Ear:	Infections	Pain	Ringing	Clicking	Popping
Nose:	Runny	Stuffy	Sneezing	Nose Bleeds	
Throat:	Sore	Hoarseness	Swollen Glands		
Eye:	Itching	Burning	Tearing	Pain	
Lung:	Wheeze	Short of Breath	Cough		
Gastrointestinal:	Nausea	Vomiting	Diarrhea	Pain	
Hematology:	Bruising	Bleeding	Blood Clots		
Cardiovascular:	Flushing	Palpitations	Chest Pain		
Musculoskeletal:	Arthritis	Fractures	Osteoporosis		
Child Development:	Premature	Low Birth Weight			
Skin:	Eczema	Hives	Itching	Rash	
Neurology:	Fainting	Headache	Weakness	Seizures	
Psychiatric:	Stress	Anxiety			
Endocrine:	Excessive Thirst	Frequent Urination			
Sleep:	Snoring	Insomnia	Sleep Apnea		

Review with Patient: ______________________________

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Do you have: DIABETES, HIGH BLOOD PRESSURE or OTHER MEDICAL PROBLEMS ______________________________

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List Past Medical Problems: ______________________________

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Have you had Sinus Surgery: YES or NO, If YES ______________________________

Any Other Surgeries: ______________________________

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Insect Sting Allergies: (9) **Type -** YELLOW JACKET, WASP, HORNET, HONEY BEE, FIRE ANT, UNKNOWN INSECT

Resulting Reaction - HIVES, DIFFICULTY BREATING, SWELLING, WHEEZING, SHOCK

Are your nose or eyes worse if you are near: DUST, DOG, CAT, WEATHER CHANGE, GRASS CUTTING, MOLD, SMOKE, FUMES, PERFUMES

Do you have any pets: (3)

DOG - (46) Stays Strictly Outdoors, (54) Indoors, NOT Allowed in Bedroom, (52) Indoors, Allowed in Bedroom (53)

CAT - (47) Stays Strictly Outdoors, (54) Indoors, NOT Allowed in Bedroom, (52) Indoors, Allowed in Bedroom (53)

OTHER PETS: ______________________________

Are you in contact with any indoor pets elsewhere on a weekly basis: ______________________________

Were there previous pets in you house or apartment: YES or NO

Do you have any children under 10-years of age: (113) YES or NO **How many:** __________ **Ages of Children:** (114) __________

Does your child attend: DAYCARE PRE-SCHOOL KINDERGARTEN

Does your job require you to be around young children? ______________________________

Do you teach: (111) YES or NO **If yes:** PRE-SCHOOL KINDERGARTEN ELMENTARY MIDDLE HIGH SCHOOL

Environment:

Carpeting: BEDROOM, OTHER ROOMS: ______________________________

Mustiness or Dampness in Basement: YES or NO

Do you have a feather pillow: (79) YES or NO

Do you have a down comforter: (80) YES or NO

Personal:

Marital Status: M S D W **Employment:** ______________________________

Do you now or have you ever smoked? (78) ______________________________

Do you have any family members with asthma or allergies? (33)

MOTHER, FATHER, BROTHER, SISTER, CHILDREN, OTHER ______________

Medications

Do you have a runny nose or wheezing when you take aspirin, Advil or Aleve: YES or NO

Have you taken any of these in the Last Month: ALLEGRA, CLARITN, ZYRTEC, FLONASE, NASONEX, NASACORT, RHINOCORT (18)

Have you ever taken: ALLEGRA, CLARITN, ZYRTEC, FLONASE, NASONEX, NASACORT, RHINOCORT (28)

Medication Allergies: (10A) Type - PENICILLIN, SULFA, ERYTHROMYCIN, OTHER ______________________________ Taken: Orally or Shot

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List your Current Medications: ______________________________

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REVIEWED BY: ______________________________