ALLERGY & CLINICAL IMMUNOLOGY MEDICAL GROUP

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NAME _____ ***D.O.B.*** _____ ***DATE*** _____

REFERRED BY _____ ***PRIMARY CARE PHYSICIAN*** _____

REASON FOR VISIT TODAY _____

How long have you had these problems? _____

Have you seen an allergist in the past? ☐ Yes ☐ No
Were you allergy tested? ☐ Yes ☐ No
Have you been on immunotherapy (allergy shots) before? ☐ Yes ☐ No

Other Medical Conditions _____

MEDICATION	*DOSE*	*FREQUENCY*	*MEDICATIONS*	*DOSE*	*FREQUENCY*

Past medication or interventions you have tried: _____

Allergies:

Known Drug Allergies: ☐ No ☐ Yes: drug(s) _____

Other allergies (foods, insect stings) _____

Surgical History: _____

Previous Hospitalizations: _____

Family History: ☐ Adopted/Non-Contributory

	Which blood relative(s)? Mother	Father	Siblings
Asthma			
Immunodeficiency			
Hay fever/Seasonal Allergies			
Food Allergy			
Eczema			
Unknown			

Social History:

Whom do you live with? ☐ Alone ☐ Spouse/adult(s) _____ ☐ Parent(s) _____ ☐ Children _____

Smoking:

☐ Non-smoker
☐ Current smoker Year started _____ ☐ Cigars ☐ Cigarettes
☐ Former smoker Year quit _____
☐ Exposure to second hand smoke ☐ Yes ☐ No

Drinking: ☐ Yes ☐ No
How often, drinks per day? _____ ☐ Drinks per month? ____

Home Environment:

☐ House ☐ Apartment ☐ Condo ☐ Boat

Constructed after 1980: ☐ Yes ☐ No Renovated since 1980: ☐ Yes ☐ No

How long have you lived there? _____

Flooring: ☐ Wood ☐ Tile ☐ Carpet ☐ Laminate ☐ Other_____

Environmental Controls: ☐ Pillow encasements ☐ Mattress encasement ☐ Air filter

Pets/Animals:

☐ None ☐ Cats ☐ Dogs ☐ Birds ☐ Livestock ☐ Other _____

Have you had any of the following symptoms in the past month?

General
☐ Chills
☐ Difficulty Sleeping
☐ Fatigue
☐ Fever
☐ Sweats
☐ Weight Gain/Loss

Eyes
☐ Blurred Vision
☐ Discharge
☐ Itching
☐ Redness
☐ Swelling
☐ Glasses/Contacts

Ears
☐ Drainage
☐ Infections
☐ Pain
☐ Popping
☐ Itching
☐ Hearing Loss
☐ Ringing

Nose
☐ Drainage
☐ Congestion
☐ Itching
☐ Polyps
☐ Nose Bleeds
☐ Sneezing
☐ Sinus pain

Throat
☐ Difficulty Swallowing
☐ Hoarseness
☐ Snoring
☐ Sore Throat
☐ Throat Itching
☐ Throat Swelling
☐ Post Nasal Drip

Psych
☐ Agitation
☐ Anxiety
☐ Depression
☐ Moodiness
☐ Nervousness
☐ Panic
☐ Stress

Respiratory
☐ Chest Tightness
☐ Cough
☐ Shortness of Breath
☐ Sputum/Mucous __Clear __Colored
☐ Wheezing

Cardio/Vas
☐ High Blood Pressure
☐ Chest Pain
☐ Difficulty Lying Flat
☐ Palpitations
☐ Swelling in Hands/Feet

G.I.
☐ Abdominal Pain
☐ Change in Appetite
☐ Constipation
☐ Diarrhea
☐ Heartburn/Indigestion
☐ Nausea/vomiting

Skin
☐ Acne
☐ Flushing
☐ Hives
☐ Moles
☐ Rash
☐ Scaly Skin
☐ Dryness
☐ Itching

Endocrine
☐ Cold/Heat Intolerance
☐ Diabetes
☐ Excessive Thirst
☐ Thyroid Problems
☐ Enuresis

Neurological
☐ Dizziness
☐ Double Vision
☐ Migraines
☐ Numbness
☐ Tension Headaches
☐ Tingling
☐ Weakness

Mus/Skel
☐ Back Pain
☐ Joint Pain
☐ Muscle Pain
☐ Muscle Weakness
☐ Swollen Joints

Immunizations:

☐ Pneumovax Date_____ ☐ Prevnar 13 Date_____ ☐ Flu Date_____

☐ Childhood vaccines current? Yes___ No___