Allergy and Asthma Center , Anita N Wasan MD PLC

Date of Visit:

Patient Name:

Address:
Cell phone number:
Email address:
Insurance name & ID:
Subscriber name, DOB, social security number

Reason(s) for Visit:	
Are you able to get skin tested today? (You have not had any antihistamines for 3-5 days)	
Do you take beta blockers for heart palpitations/ high blood pressure/anxiety?	
Do you have trouble breathing/ cough/shortness of breath? If yes, you may need breathing tests done.	

Please list primary care provider and any specialist physicians you see including city, state

Please list any hospitalizations, surgeries, and medical conditions you have

Any drug allergies? If yes, please list approximate age of reaction and symptoms

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List all medications (prescription and over-the-counter) including dosage

Type of housing (i.e. single family home, townhome, condo, apt)	
When was the home built?	
Any pets? If yes, please list how many and what type.	
Do you smoke? Have you ever smoked? Are you exposed to smoke? Include e-cigarettes and marijuana and hookah	
How many alcoholic beverages do you drink per week, on average?	
Does your home have carpeting? Where and how old?	
Any mold or water damage in the home?	
Do you change your air filters? If yes, how often?	
Any indoor plants? Where and how many?	
Do you snore? Any nightly awakenings? Mouth breathing at night? Do you wake up in the morning feeling well rested?	
How often do you change your sheets and pillowcases? How old is your mattress?	
How many servings (8 oz) of caffeine do you drink per day? Include coffee, sodas, iced tea, etc.	
Do you eat spicy foods 2-3 times a week or more? Do you have difficulty swallowing?	

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Please list any medical conditions that exist in your family

For those patients with hives, rashes, sensitive skin, and/or eczema:	
Name of body wash/soap:	
Name of washing detergent:	
Do you use dryer sheets and/or fabric softener?	
Use of perfumes/colognes/body sprays?	

Preferred pharmacy name, location

Circle any symptoms that pertain to you:			
Headaches	Nasal congestion	Suicidal thoughts	Lymph node swelling
Vision loss/changes	Trouble falling asleep	Nerve pain/tingling	Breast lumps/ masses
Hearing loss/changes	Trouble staying asleep	Arthritis/ joint pain	Constipation
Sinus pressure	Snoring	Rash / eczema	Diarrhea
Post nasal drip/ throat clearing	Mouth breathing	Hives	Bloating / gas
Cough	Heart palpitations	Difficulty in moving extremities	Abdominal pain
Chest pain	Depression	Swelling	Nausea / vomiting
Shortness of breath	Anxiety	Neck pain	Difficulty in urination
Menstrual irregularities	Hair loss	Cold/ heat intolerance	Thyroid problems
Difficulty breathing with exercise/ exertion	Frequent illnesses	Food allergies	Food sensitivities

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