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___