Please list the Medical Provider who referred you to our office: _________________________________

What is your chief complaint or primary reason for coming in today?

- Nasal Allergies
- Asthma/Trouble Breathing
- Eczema
- Rash
- Post Nasal Drip/Drainage
- Cough
- Eye Allergies
- Possible Food Allergies
- Hives
- Sinus Infection
- Skin Swelling
- Other: _________________________________

PAST MEDICAL HISTORY:

Has the patient been diagnosed with one of the following conditions: Please check all that apply.

- None
- Eye Allergy
- Seasonal Allergies
- Asthma
- Eczema
- Contact Allergy
- Chronic Sinus Infections
- Drug Allergy
- Eosinophilic Esophagitis
- Angioedema
- None
- Ant
- Yellow Jacket/Hornet
- Bee
- Wasp
- Yes, but not identified

Which of the non-allergy conditions has the patient been diagnosed with: (Please check all that apply)

- None
- Acid Reflux
- High Thyroid
- Sleep Apnea
- Lactose Intolerance
- Anxiety
- High Blood Pressure
- Heart Disease
- Celiac Disease
- Depression
- COPD
- Lupus
- Food Intolerance or Sensitivity
- Low Thyroid
- Emphysema
- Rheumatoid Arthritis

Has the patient ever been allergy tested before? Circle one: YES   NO

Has the patient ever been on allergy shots? Circle one: YES   NO

Are the Patient’s immunizations up to date?
Patient Name: _____________________ Date of Birth:________________

- Yes
- No
- Immunizations
- Incomplete
- Delayed Schedule

Has the patient ever been hospitalized overnight for Pneumonia, RSV, Asthma, or Bronchitis? (Do not include ER and Urgent Care visits where patient was sent home same day.)

- No
- Pneumonia
- Asthma
- RSV
- Bronchitis

Has the patient ever been admitted in a hospital ICU, NICU, or PICU? Please include approximate date and reason.

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<tr>
<th>ICU, NICU, or PICU</th>
<th>Reason</th>
<th>Approximate Date</th>
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**SURGICAL HISTORY:**

Has the patient ever undergone any of the following procedures: (Please check all that apply)

- None
- Tonsillectomy
- Adenoidectomy
- Sinus Surgery
- Tubes in Ears

Please list any other major surgeries the patient has undergone: (Please include Approximate Date)

- NONE

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<thead>
<tr>
<th>Surgery:</th>
<th>Approximate Date:</th>
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**FAMILY HISTORY:** Does Patient’s Mom, Dad, Brother, Sister, or Children have any of these conditions: Please check all that apply and **please note next to each condition which family member (e.g. Allergies – Mom)**

- None
- Allergies
- Food Allergy
- Eczema
- Drug Allergy
- Thyroid Issues
- Eosinophilic Esophagitis
- Lupus
- Rheumatoid Arthritis
- Ulcerative Colitis
- Angioedema
- Crohn’s Disease
- Asthma
- Cancer
- Arthritis
- Food Allergy
- Thyroid Issues
- Crohn’s Disease
SOCIAL HISTORY: Does the patient currently use or consume any of the following? (Please check all that apply)

- N/A
- Alcohol
- Drugs
- Cigarettes
  - Packs per day _____
  - How long did you smoke? _____
  - Quit Date? _____

ENVIRONMENTAL HISTORY:

Does the patient have any of these pets living with them at home?

- None
- Dog
- Cat
- Horse
- Other:_______

Do you have or use any of the following items: (Please check all that apply)

- HEPA Filter
- Dust Mite covers for pillow or blanket
- Carpet in most of the home
- Air Ionizer
- Feather Comforter
- No Carpet/Very Little Carpet
- Humidifier
- Feather Pillows
- Vaporizer
- Carpet in Bedrooms

FOOD ALLERGIES: Has the patient ever been officially diagnosed with one of the following food allergies and prescribed Epinephrine?

- None
- Milk
- Tree Nuts
- Shellfish
- Peanut
- Egg
- Soy
- Fish
- Wheat

CURRENT MEDICATIONS: Please list all current medications: (Please include all allergy and non-allergy medications)
REVIEW OF SYMPTOMS (ROS): Is the patient experiencing any of these symptoms? Please check all that apply.

- Fever
- Weight Gain/Loss
- Eye Pain
- Shortness of Breath
- Sputum
- Dark Stool
- Painful Urination
- Morning Stiffness
- Easy Bruising
- Numbness
- Too Hot/Cold
- Frequent Throat Clearing
- Cold Sores
- Sniffing
- Stuffy Nose
- Nose Surgery
- Broken Nose
- Headaches
- Blurred Vision
- Chest Pain
- Wheezing
- Abdominal Pain
- Nausea/Vomiting
- Urinary Frequency
- Cramps
- Rashes
- Dizzy Spells
- Tired/Sluggish
- Frequent Tonsillitis
- Sneezing
- Watery Mucus
- Sinus Infections
- Polyps
- Loss of Smell
- Chills
- Double Vision
- Palpitations
- Frequent Cough
- Indigestion
- Urine Retention
- Joint Pain
- Easy Bleeding
- Tremors
- Excessive Thirst
- Sore Throat
- Itchy Throat/Hoarseness
- Itching
- Nose Bleed
- Snoring
- Post-Nasal Drip
- None

MEDICATION INFORMATION: What medications has the patient used? (Please check all that apply)

- Zyrtec/Cetirizine
- Hydroxyzine
- Xyzal/Levocetirizine
- Rhinocort
- Veramyst
- Atravein/Ipratopium Bromide Nasal Spray
- Albuterol via nebulizer
- Advair
- Dulera
- Zaditor/Ketotifen
- Pataday
- Claritin/Loratadine
- Benadryl
- Flonase/Fluticasone
- Nasonex
- Astelin/Azelastine
- ProAir
- Budesonide/Pulmicort
- Qvar
- Breo
- Pazeo
- Other: __________________
- Allegra/Fexofenadine
- Singularair/Montelukast
- Nazacort
- Qnasl
- Dymista
- Ventolin
- Flovent
- Symbicort
- Arnout
- Visine Allergy

Has the patient taken any antihistamines or medications containing antihistamines within five (5) days of the appointment? Including, but not limited to the following medications: Zyrtec, Claritin, Allegra, Xyzal, Alavert, Unisom, Zantac, Pepcid, Meclizine, Tylenol PM, Cold and Sinus Medicine. Circle one: YES NO