



Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

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
- Eosinophilic Esophagitis
- Seasonal Allergies
- Contact Allergy (Latex/Jewelry/etc.)
- Angioedema
- Asthma
- Chronic Sinus Infections
- Eczema
- Drug Allergy

Has the patient ever been formally diagnosed with an insect allergy that required Epinephrine and/or emergency medical services (911, ER visit, ambulance)? If so, which insect?

- None
- Wasp
- Ant
- Yellow Jacket/Hornet
- Bee
- 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?



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- 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.

ICU, NICU, or PICU	Reason	Approximate Date

**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

Surgery:	Approximate Date:

**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)**

- |  |                                    |  |                                       |
|--|------------------------------------|--|---------------------------------------|
| <input type="radio"/> None                     | <input type="radio"/> Allergies    | <input type="radio"/> Asthma               | <input type="radio"/> Food Allergy    |
| <input type="radio"/> Eczema                   | <input type="radio"/> Drug Allergy | <input type="radio"/> Cancer               | <input type="radio"/> Thyroid Issues  |
| <input type="radio"/> Eosinophilic Esophagitis | <input type="radio"/> Lupus        | <input type="radio"/> Rheumatoid Arthritis | <input type="radio"/> Crohn’s Disease |
| <input type="radio"/> Ulcerative Colitis       | <input type="radio"/> Angioedema   |  |                                       |



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**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
- Peanut
- Wheat
- Milk
- Tree Nuts
- Shellfish
- Egg
- Soy
- Fish

**CURRENT MEDICATIONS:** Please list all current medications: (Please include all allergy and non-allergy medications)




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**REVIEW OF SYMPTOMS (ROS):** Is the patient experiencing any of these symptoms? Please check all that apply.

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

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

- |  |  |   |
|--|--|---|
| <input type="radio"/> Zyrtec/Cetirizine                        | <input type="radio"/> Claritin/Loratadine  | <input type="radio"/> Allegra/Fexofenadine  |
| <input type="radio"/> Hydroxyzine                              | <input type="radio"/> Benadryl             | <input type="radio"/> Singulair/Montelukast |
| <input type="radio"/> Xyzal/Levocetirizine                     | <input type="radio"/> Flonase/Fluticasone  | <input type="radio"/> Nasacort              |
| <input type="radio"/> Rhinocort                                | <input type="radio"/> Nasonex              | <input type="radio"/> Qnasl                 |
| <input type="radio"/> Veramyst                                 | <input type="radio"/> Astelin/Azelastine   | <input type="radio"/> Dymista               |
| <input type="radio"/> Atrovent/Ipratropium Bromide Nasal Spray | <input type="radio"/> ProAir               | <input type="radio"/> Ventolin              |
| <input type="radio"/> Albuterol via nebulizer                  | <input type="radio"/> Budesonide/Pulmicort | <input type="radio"/> Flovent               |
| <input type="radio"/> Advair                                   | <input type="radio"/> Qvar                 | <input type="radio"/> Symbicort             |
| <input type="radio"/> Dulera                                   | <input type="radio"/> Breo                 | <input type="radio"/> Arnuity               |
| <input type="radio"/> Zaditor/Ketotifen                        | <input type="radio"/> Pazeo                | <input type="radio"/> Visine Allergy        |
| <input type="radio"/> Pataday                                  | <input type="radio"/> Other: _____         |   |

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