ARIZONA ALLERGY ASSOCIATES

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?

- ○ 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)**

- ○ None
- ○ Eczema
- ○ Eosinophilic Esophagitis
- ○ Ulcerative Colitis
- ○ Allergies
- ○ Drug Allergy
- ○ Lupus
- ○ Angioedema
- ○ Asthma
- ○ Cancer
- ○ Rheumatoid Arthritis
- ○ Food Allergy
- ○ Thyroid Issues
- ○ Crohn's Disease

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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.

- ○ 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
- ○ Sniffling
- ○ 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
- ○ Atrovent/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
- ○ Singulair/Montelukast
- ○ Nasacort
- ○ Qnasl
- ○ Dymista
- ○ Ventolin
- ○ Flovent
- ○ Symbicort
- ○ Arnuity
- ○ 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