ALLERGY ASSOCIATES
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NEW ALLERGY PATIENT HISTORY FORM

Patient's Name: _____

Age: _____ Sex: _____ Date of birth: _____

Primary doctor: _____ Referred by: _____

Pharmacy name and address:_____

1. Problems for which we are seeing you:

_____ _____ _____

_____ _____ _____

2. Past medical history: (Please circle all that apply)

Cancer	Breast, Brain, Lung, Pancreatic, Ovarian, Prostate, Stomach, Liver, Colon, Skin, Cervical, Esophageal, Other:
Cardiac	Stroke, Hypertension, Palpitations, Pacemaker
Eyes	Glaucoma, Blindness, Cataracts
Ears	Hearing loss, Chronic ear infections
Nose	Nasal polyps, Nosebleeds, Nasal congestion, Allergic rhinitis, Chronic sinusitis
Skin	Rash, Eczema, Hives, Acne, Hair loss, Nail disorders
Musculoskeletal	Arthritis, Osteoporosis, Chronic back pain
Endocrine/ Rheumatology	Diabetes, Thyroid disease, Autoimmune disorder, Addison's disease, Scleroderma, Lupus, Other:
Gastrointestinal	Reflux, Eosinophilic esophagitis, Hernia, Ulcer, Polyps, Inflammatory bowel disease (IBD-Crohn's or UC), Irritable Bowel Syndrome (IBS)
Urinary/Reproductive	Kidney disease, Breast Disease, Prostate Disease
Respiratory	Asthma, COPD, Chronic bronchitis, Tuberculosis, Pneumonia, Emphysema, Sleep Apnea- on CPAP? Yes No
Neurological	Epilepsy, Seizures, Migraines, Memory loss, Stroke
Psych/Social	Depression, Anxiety, Bipolar, OCD, Insomnia

Other: _____

3. Have you been seen by an allergist before? Yes No
If yes, have you had previous skin testing or blood testing for allergies? Yes No
Were you ever on allergy shots? Yes No If yes, when and for how long_____

4. Past surgical history (please list operations and dates):

_____
_____

5. Medications (include dose and frequency):

_____
_____
_____

6. Drug Allergies: (Please briefly describe reaction)

_____
_____

7. Food Allergies: (Please briefly describe reaction)

_____
_____

8. Vaccinations:
Are your vaccinations up to date? Yes No Any adverse reactions to vaccinations? Yes No
Have you received the pneumonia vaccine: Yes No If yes, when: _____
Are you up to date for the flu vaccine this year? Yes No

9. Penicillin and venom allergy:
Do you have a history of penicillin allergy? Yes No
If yes, when and please describe reaction: _____
Have you ever had a reaction to a bee, wasp, hornet or fire ant sting? Yes No
If yes, please describe reaction: _____

10. Family history (check all that apply):

	Asthma	Allergies	Immune Disorder	Other (list)
Father				
Mother				
Brother				
Sister				
Paternal GF				
Paternal GM				
Maternal GF				
Maternal GM				

Other: _____

11. Social history:
Do you currently smoke? Yes No
If yes, amount: _____ For how long have you smoked?_____
Previous smoker: Yes No Start date: _____ Stop date: _____
What is your occupation? _____
What are your hobbies:_____
Alcohol use: Yes No Drug dependence: Yes No

12. Environmental history:
How long have you lived in this area? _____
Are you a permanent resident in this area? Yes No
If you are not a permanent resident, where is home? _____
Do you have symptoms at your permanent home? Yes No
What items are in your bedroom? Dust, Books, Blinds, Stuffed animals, Carpeting, Pets, Curtains, Feathers, Furniture, plants, other_____
Do you have any pets at home? Yes No If yes, what pets? _____
If you have pets are they allowed in your bedroom? Yes No
How long have each of your pets been in your home: _____
Outdoor clothes line: Yes No
Please circle if you have any of the following in your home: Dust, carpeting, cockroaches, mice/rats, leaks, mold, other _____

13. Review of systems (Please circle if you are experiencing any of the symptoms below):

Constitutional	Unexpected weight change, fever, chills, weakness, fatigue
Eyes	Pain, vision disturbance, eye watering, eye itching, eye redness
Ears, Nose, Throat	Hearing loss, ear pain, sneezing, nasal congestion, runny nose, decreased sense of smell, itchy throat, sore throat
Skin	Rash, hair loss
Cardiovascular	Chest pain, chest pressure, palpitations
Respiratory	Shortness of breath, cough
Gastrointestinal	Nausea, vomiting, diarrhea, abdominal pain, bloody stools
Genitourinary	Burning on urination, urge to urinate, increased frequency of urination
Neurological	Headache, dizziness, fainting, numbness, tingling
Musculoskeletal	Back pain, joint pain, stiffness
Hematologic	Anemia, easy bleeding or bruising
Psychiatric	Depression, anxiety
Endocrine	Cold intolerance, heat intolerance, excessive thirst, excessive urination