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ALLERGY & ASTHMA ASSOCIATES

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New Patient History

Name: _____ DOB: _____

Referring Physician: _____

WHAT IS THE MAIN REASON FOR TODAY'S VISIT (*Please be specific*)?

CURRENT MEDICATIONS (Name/Dose/Frequency – *Please include over-the-counter medications, vitamins, oral contraceptives*):

1.	4.
2.	5.
3.	6.

DRUG ALLERGIES

Medication	Date of Reaction	Nature of Reaction

FOOD ALLERGIES

Food	Date of Reaction	Nature of Reaction

PAST MEDICAL HISTORY

- Please list **all chronic medical conditions** (ie: High Blood Pressure, Diabetes):_____

  _____
- Please list any **surgeries** you have had:_____

FAMILY HISTORY (*Please check off appropriate history*)

	Father	**Mother**	**Siblings**	**Extended Relatives**
Asthma				
Allergies (Seasonal/Food/Drug)				
Eczema				
Immune Disorder				

SOCIAL HISTORY

- Who lives in the home with you? _____
- What is your occupation? _____
  - If student, what grade are you in? _____

(OVER)

ENVIRONMENTAL HISTORY

- Do you have any pets? ☐ Cat(s) ☐ Dog(s) ☐ Bird(s) ☐ Other _____
  - If yes, are they allowed in the bedroom? ☐ Yes ☐ No
- Do you have central air conditioning? ☐ Yes ☐ No
- Do you typically keep windows in your home open, weather permitting? ☐ Yes ☐ No
- Do you have carpeting in your bedroom? ☐ Yes ☐ No
- Do you, or anyone else in your home, smoke cigarettes? ☐ Yes ☐ No
- Do you have any issues with mold/dampness in the house? ☐ Yes ☐ No
- Are your pillow and mattress new? (within past 3 years) ☐ Yes ☐ No
- Do you have dust mite encasements on your pillow/mattress? ☐ Yes ☐ No
- Are there any down/feather products in your home? ☐ Yes ☐ No

UPPER AND LOWER RESPIRATORY SYMPTOMS

NOSE	EYES	SINUS	OTHER (EAR/THROAT)
☐ Nasal Congestion ☐ Runny Nose ☐ Itchy Nose ☐ Post-Nasal Drip	☐ Red Eyes ☐ Watery Eyes ☐ Itchy Eyes	☐ Sinus Pressure/Pain ☐ Poor Sense of Smell ☐ Frequent Sinus Infections	☐ Frequent Ear Infections ☐ Hoarse voice ☐ Acid Reflux (GERD)

CHEST/LUNGS
☐ Frequent Cough ☐ Wheezing ☐ Chest Tightness ☐ Shortness of Breath ☐ Recurrent Pneumonias

- Are the above symptoms seasonal? ☐ Spring ☐ Summer ☐ Fall ☐ Winter
- Are there triggers for above symptoms? ☐ Pollen ☐ Cat/Dog ☐ Dust ☐ Mold ☐ Smoke ☐ Exercise ☐ Viral Illnesses

- Have you ever been **skin tested** before? ☐ Yes ☐ No
- Have you ever been on **allergy shots** before? ☐ Yes ☐ No
- Have you ever used a **nebulizer/inhaler** before? (*ex: Albuterol, Xopenex*) ☐ Yes ☐ No
- Have you ever smoked **Tobacco** (cigarettes)? ☐ Yes ☐ No
  - If YES, packs/day? _____ When did you start? _____ If quit, since when? _____

SKIN ISSUES

Do you have a history of:

☐ **Eczema** (*If yes, answer questions below*)

- What prescription creams/ointments have you tried? _____
  _____
- What brand soap do you use? _____
- What brand moisturizer do you use? _____

Aside from previously mentioned food/drug reactions, do you have a history of:

☐ **Recurrent Hives**

☐ **Angioedema** (swelling of body parts)

OTHER ALLERGY CONCERNS:

☐ Have you had a severe reaction in the past to a **bee/wasp/hornet/yellow jacket sting**?

☐ Have you had an allergic/adverse reaction to **Latex** products?

HOW DID YOU HEAR ABOUT OUR PRACTICE?

☐ Primary Physician ☐ Search Engine (*ie: Google*) ☐ Social Network/Forum (*ie: Facebook*)

☐ Friend/Current Patient_____ ☐ Other_____

(Name) (Please list)