



**Allergy &
Asthma Center, P.C.**
PHYSICIANS

Patient's Name _____ Birthdate ____/____/____ Appointment Date ____/____/____

Briefly describe reason for allergy visit: _____

Have you ever had the following conditions? (Write YES or NO for each item):

	Present problem	Past problem	Age at onset	Mild: 1-2 days/week	Moderate: 2-5 days/week	Severe: 5+ days/week
Runny nose						
Sneezing						
Itchy nose						
Stuffy or congested nose						
Sinus problems						
Wheezing						
Persistent coughing						
Chest tightness						
Shortness of breath						
Bronchitis or prolonged coughing with "colds"						
Pneumonia						
Emergency room visit for breathing problems						
Hospitalization for breathing problems						

Check any symptoms that occur after vigorous exertion or exercise:

- coughing wheezing chest tightness throat clearing

Are your symptoms worse during certain months of the year? Yes No

Which months? _____

If yes, do you have mild symptoms year around? Yes No, am well rest of the year

Check any conditions that make your symptoms worse:

- mowing the lawn, exposure to cut grass, playing in grass
- raking leaves
- sweeping, dusting, using vacuum cleaner
- being around animals or the places where animals live
- moldy or mildewed areas
- tobacco smoke or other fumes
- strong odors or perfumes
- anything else?

Specify: _____

Other Allergies:

Have you ever had the following conditions? (Check each item)

	Present problem	Past problem	Age at onset	Mild	Moderate	Severe
Drug allergy or reaction to medication					SEE BELOW	
Severe bee sting reaction						
Food reactions						
Severe or recurrent hives						
Poison oak or other contact allergic reactions						
Eczema or other skin allergies						
Headaches						
Stomachache						
Leg aches						

If yes to **DRUG ALLERGY:**

Date of reaction(s) _____

I reacted to the following medication:

penicillin sulfa aspirin

other (specify) _____

I had the following reaction:

rash swelling hives trouble breathing shock

other (specify): _____

If yes to **BEE STING** (honey bee, yellow jacket, hornet, wasp)

Date of sting(s) _____

I had the following reaction: large local swelling around the sting only trouble breathing

hives or swelling on other parts of my body vomiting feeling faint

Food reactions:

I have had reactions to the following food(s):

milk eggs fish peanut nuts

other (specify) _____

I get the following symptoms from these foods: stomachache loose bowels (diarrhea) nausea

rash stuffy nose asthma other (specify) _____

For physician (leave blank):

Past Health:

List all hospitalizations and operations:

Date	Reason

Yes No Have you had sinus surgery? Date _____

Review of Systems:

Have you ever had any of the following?

YES	NO		YES	NO	
		Frequent headaches			Stomach or digestive problems
		Ear infections			Kidney trouble
		Glaucoma			Liver trouble
		Heart trouble			Tuberculosis
		High blood pressure			Seizures
		Thyroid problems			Diabetes

Date of last chest x-ray: _____ Date of last sinus CAT scan: _____

What other medical problems have you had? _____

Family Health:

Yes No Is there a history of allergy in your family (parent, grandparents, brothers, sisters, children, aunts, uncles)? If yes, list:

	Relationship
Allergy	
Hay fever	
Asthma	
Sinus problems	
Eczema	
Hives	

For physician (leave blank):