PATIENT INFORMATION FOR ALLERGY VISIT

Date: ______________________________

Name: ______________________________ Age: ______________________________

Occupation: ______________________________

Referred By: ______________________________ Primary Physician: ______________________________

What problems are you here for today? ______________________________

____

Past Medical Illness (circle):

Asthma	**Hayfever**	**Eczema**	**Heart Disease**	**Bronchitis**
Diabetes	**Cancer**	**Ulcers**	**Kidney Disease**	**Liver Disease**

Other:

Previous allergy skin testing? **Y** **N** **If yes, when?** ____________ **Where?** ____________

Previous allergy shots? **Y** **N** **If yes, when?** ____________ **Where?** ____________

Allergic to any medicine? Please list: ______________________________

____

Have you been given steroids (e.g. Cortisone) by pill or injection in the past? **YES** **NO**

If yes when and for how long? ______________________________

Do you smoke? **Y** **N** **Average Packs/Day:** ______ **Years:** _____ **When did you quit?** _____

Did you ever smoke? **Y** **N** **Alcohol? :** ______________________ **Per Day**

Immediate Family History of: **Asthma** **Hay Fever** **Eczema**

Heart Disease **Diabetes** **Cancer** **High Blood Pressure**

Other: ______________________________

<u>Home Environment</u>: Age of home: _____ **Carpeted:** **Y** **N** **Central A/C:** **Y** **N**

Pets: ______________________ **Tobacco Smoke:** **Y** **N** **Feather Pillows:** **Y** **N**

Visible Mold: ______________________ **Wood burning Fireplace:** **Y** **N** **Ceiling Fans:** **Y** **N**

(This section only: To be filled out by medical staff)

General	**HEENT**	**Resp**
CV	**GI**	**GU**
MS	**Endo/Heme**	**Neuro**