



Allergy & Asthma Care

Patient's Name
Address
City State Zip
Date of Birth
Gender Male Female
Race Ethnicity
Language 1st: 2nd:
Home Phone
Work Phone
Cell Phone
Occupation
Employer
Address
City State Zip

Please complete if the patient is a minor (under 18)

Father's Name
Address
City State Zip
Home Phone
Work Phone
Cell Phone
Date of Birth
Occupation
Employer

Spouse's Name
Address
City State Zip
Date of Birth
Employer
Address
City State Zip
Work Phone

Mother's Name
Address
City State Zip
Home Phone
Work Phone
Cell Phone
Date of Birth
Occupation
Employer

Family Doctor/Pediatrician
Address
City State Zip
Phone

Pharmacy Name
Address
City State Zip
Phone Fax

Who is the subscriber on your insurance? Self Spouse Mother Father
How did you hear about us?
If referred, who referred you?
May we contact you by email regarding newsworthy information? Yes/No Email:

Patients under the age of 18 must be accompanied by a parent or designated adult in order to be seen.

In order to provide a high quality initial assessment, we schedule a lengthy first appointment for our new patients. If you are unable to keep this scheduled appointment, we require a 24 hour cancellation notice. If a cancellation notice is not give 24 hours in advance, a \$40 administrative fee will be charged.

The patient is responsible for:

- Co-pays (cash or check only)\* per insurance contracts at the time of each visit
Deductibles
Any portion of the bill unpaid by insurance, but listed as the patient's responsibility

\*A \$10 administrative fee will be charged if the co-payment is not paid at the time of service.

Please DO NOT wear fragrances



Patient Name: \_\_\_\_\_

Please describe in your own words the reason for your visit: \_\_\_\_\_

**EVALUATION FOR ASTHMA:**

At what age were you diagnosed with asthma? \_\_\_\_\_

Have you had any hospitalizations or ER visits for asthma? Yes / No. If yes, list approximate dates: \_\_\_\_\_

Have you been treated with steroid pills for asthma? Yes / No. If yes, how often? \_\_\_\_\_

When was the last time? \_\_\_\_\_

Have you been prescribed any of the following inhalers? Advair / Symbicort / Dulera / Flovent / Asmanex / QVAR / Pulmicort / Alvesco / Aerobid / Azmacort

What symptoms of asthma do you experience? cough / wheeze / shortness of breath / chest tightness

How many days per week do you experience these symptoms? \_\_\_\_\_

How many days per week do you use a rescue inhaler? \_\_\_\_\_

How many nights per month does your asthma hinder your ability to sleep? \_\_\_\_\_

What triggers your asthma? Exercise / laughter / crying / cold / heat / respiratory infections / change of seasons / pollens / animals / dust / mold / strong smells (such as tobacco, perfumes, detergents, etc.)

**EVALUATION FOR HAY FEVER:**

Circle the following symptoms that affect you: sneezing / runny nose / stuffy nose / post nasal drip / itchy eyes / itchy ears / itchy nose / itchy throat / watery eyes / swollen eyes / none

When do these symptoms bother you? all year long / certain months only-which months? \_\_\_\_\_

What exposures make these symptoms worse? indoors / outdoors / strong smells (such as perfumes and cleaning detergents) / rainy days / dry and windy days / cats / dogs / dust / molds / feathers or birds

What medications have you tried? \_\_\_\_\_

**EVALUATION FOR SINUSITIS:**

Do you struggle with frequent sinus infections? Yes / No. If yes, how many in a given year? \_\_\_\_\_

Have you ever had nasal polyps? Yes / No. Have you lost your sense of smell or taste? Yes / No.

Have you ever had sinus surgery? Yes / No. If yes, list dates: \_\_\_\_\_



Patient Name: \_\_\_\_\_

**EVALUATION FOR HEADACHES:**

Do you struggle with headaches? If so, circle the description of the headaches that apply: pulsating pain / constant pain / associated with intolerance of loud sounds or bright lights / worse with physical exertion / duration > 4 hours / debilitating / located on only one side of the head / located on both sides of the head

**EVALUATION FOR HIVES:**

When did current bout of hives start? \_\_\_\_\_ How often are they occurring? \_\_\_\_\_

How long does each individual hive last? \_\_\_\_\_ Are the hives intensely itchy? Yes / No

Do the hives leave any dark marks? Yes / No Have you had any illnesses before the onset of hives? Yes / No

Do you suspect any food triggers? Yes / No. If yes, what foods? \_\_\_\_\_

Do you take any ibuprofen or ibuprofen-like medications? Yes / No. If yes, list: \_\_\_\_\_

Have you noticed the hives to be worse with the following? Heat / cold / exercise / scratching / stress / showers / menses / alcohol / pressure on the skin (such as waste band and bra strap areas)

Have you ever had hives before in your lifetime? Yes / No

Have you had swelling? Yes / No. If so, where? \_\_\_\_\_

Have you had any of the following? Throat closing / shortness of breath / change in your voice / tongue swelling / a sensation of something stuck in your throat.

**OTHER ALLERGIC HISTORY:**

Do you have any food allergies? Yes / No. If yes, list each food or meal and the reaction you had to it:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Have you had any problems after bee or wasp stings? Yes / No. If yes, describe the reaction (Do not include reactions to mosquito bites): \_\_\_\_\_

Do you have any drug allergies? Yes / No. If yes, list each medication and describe the reaction:

\_\_\_\_\_  
\_\_\_\_\_

Do you have a history of latex allergy? Yes / No. If yes, describe the reaction:

\_\_\_\_\_

Do you have a history of eczema? Yes / No



Patient Name: \_\_\_\_\_

**ENVIRONMENTAL SURVEY:**

What type of heating and cooling system do you have in your home? forced air / radiator / baseboard heat / central air/ window units / wood burning heat / fans

Does anyone in your household smoke? Yes / No. If yes, where? Indoors / outdoors.

Are there any obvious mold problems? Yes / No. Do you use humidifiers? Yes / No.

Are there any young children in your home? Yes / No. If yes, list ages: \_\_\_\_\_

Is there wall to wall carpeting? Yes / No. If yes, which rooms? \_\_\_\_\_

List any family pets: \_\_\_\_\_

Do you use feather pillows, down comforters or down coats? Yes / No

**MEDICATIONS:**

List all medications you currently take (include all over-the-counter medications, eye drops, nasal sprays, inhalers, birth control pills, digestive aids, vitamins, supplements, aspirins, etc.):

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MEDICAL HISTORY:**

Please list all chronic medical conditions:

Please list all surgeries and hospitalizations with dates:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**For children under 15:** What was the birth weight? \_\_\_\_\_

Were there any complications before, during or after the delivery? Yes / No. If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Has growth and development been normal? Yes / No. If no, please explain: \_\_\_\_\_

\_\_\_\_\_



Patient Name: \_\_\_\_\_

**FAMILY HISTORY:**

Illness/Complaint	Father	Mother	Brother(s)	Sister(s)	Children	Other
Asthma						
Hay Fever						
Food Allergy						
Drug Allergy						
Eczema						
Hives						
Headaches						

**SOCIAL HISTORY:**

Occupation: \_\_\_\_\_

How much alcohol do you drink and how often? \_\_\_\_\_

Do you or did you ever smoke? Yes / No      If yes, how many packs per day on average? \_\_\_\_\_

How many years did you smoke? \_\_\_\_\_      If you no longer smoke, when did you quit? \_\_\_\_\_

Do you exercise regularly? Yes / No      If yes, what type of exercise? \_\_\_\_\_

**REVIEW OF SYSTEMS:** Please circle all that apply:

General: fever / night sweats / chills / weight loss / weight gain / severe fatigue (seasonal or all year long?)

Eyes: vision changes / redness / pain / dryness

Ears: hearing loss / ringing / popping or fullness of the ears

Mouth: problems with dentition / thrush (yeast infection) / oral ulcers

Respiratory: cough / wheeze / shortness of breath / chest tightness / frequent nose bleeds

Cardiovascular: chest pain / palpitations / lightheadedness / leg swelling

Gastrointestinal: indigestion / frequent belching / bloating / acid taste / abdominal discomfort / nausea / diarrhea

Head and Neck: headache / nose bleeds / loss of smell or taste / sinus pressure / discolored nasal discharge

Musculoskeletal: muscle pain, joint pain, weakness

Endocrine: temperature instability (feel too hot/cold), brittle hair, excessive sweating, irregular menses

Neuro/psychological: anxiety / depression / numbness / tingling / loss of consciousness / sleep disturbance