Patient Name: ____________________ Date of Birth:_____________

Please list the Medical Provider who referred you to our office: ___________________________________

What is your chief complaint or primary reason for coming in today?

- o Nasal Allergies
- o Asthma/Trouble Breathing
- o Eczema
- o Rash
- o Post Nasal Drip/Drainage
- o Cough
- o Eye Allergies
- o Possible Food Allergies
- o Hives
- o Sinus Infection
- o Skin Swelling
- o Other: _______________________________

PAST MEDICAL HISTORY:

Has the patient been diagnosed with one of the following conditions: Please check all that apply.

- o None
- o Seasonal Allergies
- o Asthma
- o Eczema
- o Eye Allergy
- o Contact Allergy (Latex/Jewelry/etc.)
- o Chronic Sinus Infections
- o Drug Allergy
- o Eosinophilic Esophagitis
- o Angioedema

Has the patient ever been formally diagnosed with an insect allergy that required Epinephrine and/or emergency medical services (911, ER visit, ambulance)? If so, which insect?

- o None
- o Ant
- o Bee
- o Wasp
- o Yellow Jacket/Hornet
- o Yes, but not identified

Which of the non-allergy conditions has the patient been diagnosed with: (Please check all that apply)

- o None
- o Lactose Intolerance
- o Celiac Disease
- o Food Intolerance or Sensitivity
- o Acid Reflux
- o Anxiety
- o Depression
- o Low Thyroid
- o High Thyroid
- o High Blood Pressure
- o COPD
- o Emphysema
- o Sleep Apnea
- o Heart Disease
- o Lupus
- o Rheumatoid Arthritis

Has the patient ever been allergy tested before? Circle one: YES NO

Has the patient ever been on allergy shots? Circle one: YES NO

Are the Patient's immunizations up to date?

Patient Name: ____________________ Date of Birth:_____________

- Yes
- No Immunizations
- Incomplete
- Delayed Schedule

Has the patient ever been hospitalized overnight for Pneumonia, RSV, Asthma, or Bronchitis? (Do not include ER and Urgent Care visits where patient was sent home same day.)

- No
- Pneumonia
- Asthma
- RSV
- Bronchitis

Has the patient ever been admitted in a hospital ICU, NICU, or PICU? Please include approximate date and reason.

ICU, NICU, or PICU	Reason	Approximate Date

SURGICAL HISTORY:

Has the patient ever undergone any of the following procedures: (Please check all that apply)

- None
- Tonsillectomy
- Adenoidectomy
- Sinus Surgery
- Tubes in Ears

Please list any other major surgeries the patient has undergone: (Please include Approximate Date)

- NONE

Surgery:	Approximate Date:

FAMILY HISTORY: Does Patient's Mom, Dad, Brother, Sister, or Children have any of these conditions: Please check all that apply and **please note next to each condition which family member (e.g. Allergies – Mom)**

- None
- Allergies
- Asthma
- Food Allergy
- Eczema
- Drug Allergy
- Cancer
- Thyroid Issues
- Eosinophilic Esophagitis
- Lupus
- Rheumatoid Arthritis
- Crohn's Disease
- Ulcerative Colitis
- Angioedema

Patient Name: ____________________ Date of Birth:_____________

SOCIAL HISTORY: Does the patient currently use or consume any of the following? (Please check all that apply)

- N/A
- Alcohol
- Drugs
- Cigarettes
- Packs per day _____
- How long did you smoke? _____
- Quit Date? _____

ENVIRONMENTAL HISTORY:

Does the patient have any of these pets living with them at home?

- None
- Dog
- Cat
- Horse
- Other:________

Do you have or use any of the following items: (Please check all that apply)

- HEPA Filter
- Dust Mite covers for pillow or blanket
- Carpet in most of the home
- Air Ionizer
- Feather Comforter
- No Carpet/Very Little Carpet
- Humidifier
- Feather Pillows
- Vaporizer
- Carpet in Bedrooms

FOOD ALLERGIES: Has the patient ever been officially diagnosed with one of the following food allergies and prescribed Epinephrine?

- None
- Peanut
- Wheat
- Milk
- Tree Nuts
- Shellfish
- Egg
- Soy
- Fish

CURRENT MEDICATIONS: Please list all current medications: (Please include all allergy and non-allergy medications)

Patient Name: ____________________ Date of Birth:_____________

REVIEW OF SYMPTOMS (ROS): Is the patient experiencing any of these symptoms? Please check all that apply.

- Fever
- Weight Gain/Loss
- Eye Pain
- Shortness of Breath
- Sputum
- Dark Stool
- Painful Urination
- Morning Stiffness
- Easy Bruising
- Numbness
- Too Hot/Cold
- Frequent Throat Clearing
- Cold Sores
- Sniffling
- Stuffy Nose
- Nose Surgery
- Broken Nose
- Headaches
- Blurred Vision
- Chest Pain
- Wheezing
- Abdominal Pain
- Nausea/Vomiting
- Urinary Frequency
- Cramps
- Rashes
- Dizzy Spells
- Tired/Sluggish
- Frequent Tonsillitis
- Sneezing
- Watery Mucus
- Sinus Infections
- Polyps
- Loss of Smell
- Chills
- Double Vision
- Palpitations
- Frequent Cough
- Indigestion
- Urine Retention
- Joint Pain
- Easy Bleeding
- Tremors
- Excessive Thirst
- Sore Throat
- Itchy Throat/Hoarseness
- Itching
- Nose Bleed
- Snoring
- Post-Nasal Drip
- None

MEDICATION INFORMATION: What medications has the patient used? (Please check all that apply)

- Zyrtec/Cetirizine
- Hydroxyzine
- Xyzal/Levocetirizine
- Rhinocort
- Veramyst
- Atrovent/Ipratopium Bromide Nasal Spray
- Albuterol via nebulizer
- Advair
- Dulera
- Zaditor/Ketotifen
- Pataday
- Claritin/Loratadine
- Benadryl
- Flonase/Fluticasone
- Nasonex
- Astelin/Azelastine
- ProAir
- Budesonide/Pulmicort
- Qvar
- Breo
- Pazeo
- Other: _________________
- Allegra/Fexofenadine
- Singulair/Montelukast
- Nasacort
- Qnasl
- Dymista
- Ventolin
- Flovent
- Symbicort
- Arnuity
- Visine Allergy

Has the patient taken any antihistamines or medications containing antihistamines within five (5) days of the appointment? Including, but not limited to the following medications: Zyrtec, Claritin, Allegra, Xyzal, Alavert, Unisom, Zantac, Pepcid, Meclizine, Tylenol PM, Cold and Sinus Medicine. Circle one: YES NO