

Family Allergy & Asthma Associates, PC
Board Certified in Pediatric and Adult Allergy

Name:	Date of Birth:	Date:
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PATIENT HISTORY

	Yes	No	Past	If yes, please explain.
General Health				
Pregnant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Weight loss or Weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fever or Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Allergy/Immunology				
Allergies or Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bee Sting/ Insect allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Drug allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Immunodeficiency	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Lupus or Rheumatoid Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
AIDS or HIV	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Eyes, Ears, Nose, Throat				
Vision problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bloody nasal discharge	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Frequent nasal drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Sinus disease/ headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Respiratory				
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Bronchitis, recurrent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cough, Wheeze, Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cystic Fibrosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Tuberculosis or '+' test	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Skin				
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Rashes or Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cardiovascular				
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gastrointestinal				
Heartburn or Ulcer disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Food intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vomiting/ Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Oncology				
Cancer- Type: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Endocrine				
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Name: _____ Date of Birth _____

OTHER MEDICAL ISSUES

MEDICATIONS (name, dosage, frequency)

HOSPITALIZATIONS (state reason)

Immunizations

Influenza (Flu) Yes No Last shot date _____
Pneumonia Yes No Last shot date _____

Family History

Family member

Allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Asthma	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Insect allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Food allergies	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Eczema	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Hives	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Immunodeficiencies	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Cancer	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
High Blood Pressure	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____
Heart Disease	Yes <input type="checkbox"/> No <input type="checkbox"/>	_____

Social History/Environmental History

Occupation _____

Do you smoke? Yes No How much? _____

Does anyone in the home smoke? Yes No

Do you drink alcohol? Yes No How much? _____

Are there any pets in the home? Yes No What type? _____

How old is your home? _____

Do you have a basement? Yes No Does it get damp? Yes No

Do you have a humidifier? Yes No

Do you have an air-conditioner? Yes No

Do you have carpeting in the bedroom? Yes No