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: _____

Home Environment: 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**