Patient Medical History

Name: _____**Date of Birth:** _____

What is your goal(s) for this visit today? _____

_____

When is the last time you took an antihistamine (Benadryl, Zyrtec, Claritin, Allegra, Zyzal, etc.)**?**

_____

For patients 65 years of age, or older: Have you received the pneumococcal vaccination?
_____ Yes _____ No

Vaccines help prevent pneumococcal disease, which is any type of illness caused by Streptococcus pneumoniae bacteria. There are two kinds of pneumococcal vaccines recommended in the United States: Pneumococcal conjugate vaccines (PCVs, specifically PCV15 and PCV20) & Pneumococcal polysaccharide vaccine (PPSV23).

If "No," would you like to receive the pneumococcal vaccination, today?

_____ Yes _____ No

Have you been experiencing any of these symptoms lately? (CHECK BOX)

Itchy Eyes___	Runny Nose___	Trouble Breathing___	Eye Swelling___
Watery Eyes___	Congested Nose___	Wheezing___	Hives___
Red Eyes___	Sneezing___	Difficulty Swallowing___	Itchy Rash___
Swollen Eyes___	Itchy Throat___	Lip Swelling___	Non-Itchy Rash___
Itchy Nose___	Cough___	Face Swelling___	Other: _____

For how long have you had these symptoms?

_____

Current Medications: Please list all prescription and over the counter medications and supplements/vitamins.

Name of Drug	**Dosage** (2 mg, 2 puffs, 1 tsp, etc.)	**Frequency** (1 x day, as needed)

<u>If you are here for Drug Allergies or Adverse Reactions</u>:

List all medications **<u>and symptoms</u>:** _____

_____

<u>If you are here for hives and/or swelling:</u>

How **<u>long</u>** have you had the symptoms?

_____

How **<u>often</u>** do you have the symptoms?

_____

What triggers your symptoms: (CIRCLE)?

Heat Cold Pressure Exercise Medications Not sure

Other: _____

<u>If you are here for insect sting allergy:</u>

When did your reaction occur? _____ What type of insect: _____

Symptoms that occurred after sting: (CIRCLE)

Swelling at sting site Lip/tongue/throat swelling Hives Trouble breathing Vomiting

Other: _____

Treatment received for reaction: _____