REDDING ALLERGY & ASTHMA SPECIALISTS

Patient Medical History

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

What is your main reason for seeing us today?_____

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

_____

For patients 65 years of age, or older: Have you received the pneumococcal vaccination?

____ Yes ____ No

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

____ Yes ____ No

Have you been experiencing any of these symptoms lately?

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)

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Patient Medical History (continued)

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

Drug Allergies or Drug Adverse Reactions? **No** ☐ **Yes** ☐

If yes, list all medications **and symptoms:** _____

_____

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

How long have you had the symptoms:

_____

How often 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: _____

_____