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.)?

_____

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)

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

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

_____

Please circle and provide details if you have ever been diagnosed with the following medical conditions:

Allergic rhinitis (nasal allergies)_____

Asthma_____

Lung Disease other than asthma_____

Respiratory /Nasal Allergies_____

Food Allergy_____

Diabetes_____

High Blood Pressure_____

Heart Disease_____

Bleeding Disorder_____

Cancer_____

Autoimmune or rheumatologic disease_____

Immunodeficiency disease_____

Genetic disease_____

Anxiety_____

If you have any other medical conditions, including psychiatric, other than the ones listed above, please list:

_____

_____

Please list all surgeries:

_____

_____

_____

Family Medical History (CIRCLE and list any parents, siblings, children):

Asthma_____

Allergic rhinitis_____

Food Allergy_____

Immunodeficiency disease_____

Genetic Disease_____

Autoimmune or rheumatologic disease_____

Any other diseases_____

Social/Environmental History:

Tobacco	**Pets**
__Non Smoker	Cats#__
__Quit (Start year:_____Stop Year:_____)	Dogs #__
__Current (Start Year:_____)	Birds #__
__Chewing/smokeless tobacco	Other :__

Do you have frequent exposure to second-hand smoke? __Yes __No

How many drinks of alcohol do you have?

Per day_____ Per week_____ None/less than 4 drinks per month

Occupation/Education

Job Title or Employer: _____

__Retired __Disabled __Unemployed __Homemaker

__Daycare __Pre-School __School __College/Graduate School

If you are here for hives and/or swelling:

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: _____

If you are here for insect sting allergy:

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: _____

_____