Allergy and Asthma
Clinical Centers

Name: _____

DOB: _____ **Date:** _____

MEDICAL AND ALLERGY HISTORY QUESTIONNAIRE

Please answer all questions to your best knowledge **and have your list of current medications available**. If necessary, have your other health care providers send us with information relating to your previous imaging studies, laboratory tests and/or treatments.

CHIEF COMPLAINT(S): _____

_____

_____

_____

New: ☐ Chronic: ☐ Duration: _____ First onset: _____

ALL YOUR CURRENT MEDICATIONS (please list ALL medications, supplements taken for any reason):

MEDICATION	DOSE (mg)	?? times / day	Comment

PAST MEDICAL HISTORY:

- ☐ High blood pressure
- ☐ Heart disease
- ☐ Stroke
- ☐ Liver disease
- ☐ Kidney disease
- ☐ Thyroid disease
- ☐ Malignancy
- ☐ Osteoporosis
- ☐ Reflux
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Other:_____
- ☐ _____
- ☐ _____

PAST SURGICAL HISTORY:

- ☐ Ear tubes
- ☐ Sinus surgery
- ☐ Tonsillectomy/adenoidectomy
- ☐ Other:_____
- ☐ _____

Your preferred pharmacy:

Name:_____

Address:_____

Phone:_____

Fax:_____

YOUR CURRENT ALLERGY SYMPTOMS

Nose	
Throat	
Ears	
Eyes	
Sinus	
Breathing	
Skin	
Hives/swelling	
Eczema	
Rashes	
Food reactions	
Insect stings	
Drug reactions	
Other	

FAMILY HISTORY

Relative	Allergies - type	Asthma	Other Illness
Father			
Mother			
Brother(s)			
Sister(s)			

OTHER CURRENT SYMPTOMS:

Constitutional

- ☐ Weight loss
- ☐ Weight gain
- ☐ recurrent fevers and chills
- ☐ night sweats
- ☐ Other_____

Cardiovascular

- ☐ irregular heartbeats/palpitations
- ☐ low blood pressure
- ☐ chest pain or burning
- ☐ loss of consciousness (black-outs)
- ☐ high blood pressure

YOUR CURRENT ALLERGY SYMPTOMS

- ☐ angina
- ☐ Other_____

Gastrointestinal

- ☐ Heartburns/reflux
- ☐ bloating
- ☐ abdominal pain
- ☐ vomiting or diarrhea
- ☐ constipation
- ☐ irritable bowel
- ☐ Other_____

Genitourinary

- ☐ painful urination
- ☐ frequent urination
- ☐ blood in urine
- ☐ kidney stones
- ☐ urinary infections
- ☐ Other_____

Musculoskeletal

- ☐ Muscle pains/aches
- ☐ Cramping
- ☐ Joint pains
- ☐ Other:_____

Neurologic

- ☐ Migraines
- ☐ Triggers:_____
- ☐ headaches
- ☐ frequency
- ☐ seen by neurologist
- ☐ prescribed
- ☐ Muscle weakness
- ☐ Other symptoms
- ☐ Visual changes
- ☐ Other_____

Endocrine

- ☐ Weight loss/gain
- ☐ Sweating
- ☐ Temperature intolerance
- ☐ Other_____

Hematology/Immunology/Oncology

- ☐ Easy bruising
- ☐ Easy bleeding
- ☐ Frequent infections
- ☐ Fatigue
- ☐ Swollen glands
- ☐ Frequent respiratory infections
- ☐ Frequent antibiotics treatment
- ☐ Other_____

Psychiatry

- ☐ Depression
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Bipolar disorder
- ☐ ADD/ADHD
- ☐ Other:_____

SOCIAL HISTORY

- ☐ Occupation:_____
- ☐ Current smoker
- ☐ > 10/day
- ☐ < 10/day
- ☐ Past smoker
- ☐ Quit > 10 years ago
- ☐ < 10 years ago
- ☐ Had flu shot
- ☐ Had pneumovax

PEDIATRIC (IF APLICABLE)

- ☐ Full term
- ☐ Breast fed
- ☐ RSV/wheezing in infancy
- ☐ Childhood immunizations up to date
- ☐ My child is in daycare
- ☐ Shares bedroom with siblings
- ☐ Has stuffed animals in bedroom

ENVIRONMENTAL SURVEY

- ☐ My dwelling is:
- ☐ > 10 years old
- ☐ < 10 years old
- ☐ In current home:
- ☐ > 3 years
- ☐ < 3 years
- ☐ Pets:
- ☐ Cat(s) indoor
- ☐ Cat(s) outdoor
- ☐ Dog indoor
- ☐ Dog(s) outdoor
- ☐ Other:_____
- ☐ Smoker in the household:
- ☐ Central HVAC
- ☐ Have moisture problems in your home
- ☐ Have a damp basement
- ☐ Have dust mite proof encasings
- ☐ On mattress
- ☐ On pillows
- ☐ Hard wood floor in bedroom
- ☐ Carpet in bedroom
- ☐ Symptoms get worse at work
- ☐ Symptoms improve away from home/on vacation