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Allergy & Asthma Specialist
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Chart #:________________

Date of consultation: __/ __/ ____

NAME:________________________
Date of Birth:__/ __/ __ Age:_____
Sex: *male* *female* Race:_______
Personal Physician:_________________________ Referring Physician:_________________________

Please answer the following questions related to your medical condition: circle and/or write

PAST MEDICAL HISTORY: List all chronic, serious, or recurrent illnesses that you ***have*** or ***had:***

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Any operations: *No* *Yes* ____
Major injuries: *No* *Yes* ____
Any hospitalizations (overnight or more): *No* *Yes* ____________________________
Previous Immunization: Chicken pox: *No* *Yes* Pneumonia: *No* *Yes* Influenza: *No* *Yes*

LIST ALL YOUR MEDICATIONS:

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

FAMILY HISTORY: What illnesses have occurred in your blood relatives?
Parents: ____
Siblings: ____
Other relatives: ____
Contagious diseases in your close contacts: *No* *Yes:* tuberculosis HIV/AIDS others:

PERSONAL, SOCIAL, & ENVIRONMENTAL HISTORY:

Smoking: *No* *Yes:___packs/day for ___ years*	Pets: *No* *Cats* *Dogs* *Others*
Past smoking: *No* *Yes:___packs/day for ___ years*	Bedroom pets: *No* *Yes*
Second hand smoking: *No* *Yes*	Previous pets: *No* *Yes*
Carpet: *No* *Living area* *Bedroom(s)*	Exposure to other animal: *No* *Yes*

PHYSICIAN'S SIGNATURE: ________________________ Notes reviewed ___ Notations added __/ __/ ____

NAME: ______________________________ CHART #: _______________ DATE: __/ __/ ____

REVIEW OF SYSTEMS: Circle all that apply to you:

EYES

Discharge ……………………………….	No	Yes
Dry eye ………………………………...	No	Yes
Eye pain ………………………………..	No	Yes
Itching ……………….………………...	No	Yes
Red eye ………………………………...	No	Yes

EARS/NOSE/THROAT/MOUTH

Nasal discharge ………………………...	No	Yes
Hoarseness ……………………………..	No	Yes
Nasal congestion ……………………….	No	Yes
Post-nasal drainage …………………….	No	Yes
Ear congestion ………………………….	No	Yes
Sneezing ………………………………..	No	Yes
Ear pain ………………………………...	No	Yes
Nosebleed ……………………………...	No	Yes
Sore throat ……………………………...	No	Yes

RESPIRATORY

Cough …………………………………..	No	Yes
Shortness of breath ……………………..	No	Yes
Wheezing ……………………………….	No	Yes

HEMATOLOGY

Swollen lymph nodes …………………..	No	Yes

CONSTITUTIONAL SYMPTOMS

Fatigue …………………………….	No	Yes
Fever ……………………………….	No	Yes

CARDIOVASCULAR

Chest pain ………………………….	No	Yes
Palpitations ………………………..	No	Yes

GASTROINTESTINAL

Diarrhea …………………………...	No	Yes
Heartburn/Acid Reflux/GERD ……	No	Yes
Nausea …………………………….	No	Yes
Vomiting …………………………..	No	Yes

NEUROLOGICAL

Dizziness …………………………..	No	Yes
Headache ………………………….	No	Yes

PSYCHIATRIC/BEHAVIORAL

Depression ………………………..	No	Yes
Anxiety …………………………...	No	Yes

SKIN

Dry skin …………………………...	No	Yes
Hives ……………………………...	No	Yes
Itching ……………………………..	No	Yes
Rash ……………………………….	No	Yes

ALLERGIC/IMMUNOLOGIC

Reactions to medications ………………	No	Yes
Reactions to food(s)/food addatives …...	No	Yes
Reactions to insect sting ………………..	No	Yes
Reactions to latex ………………………	No	Yes
Any other allergies ……………………..	No	Yes
Recurrent sinus infections/sinusitis .	No	Yes
Recurrent bronchitis/pneumonia …..	No	Yes
Recurrent infections (others) ..……. (specify below)	No	Yes

____

List all your **ALLERGIES** and describe the reaction:

____ ____

____ ____

____ ____

____ ____

____ ____

PHYSICIAN'S SIGNATURE: ______________________ Notes reviewed ___ Notations added __/ __/ ____