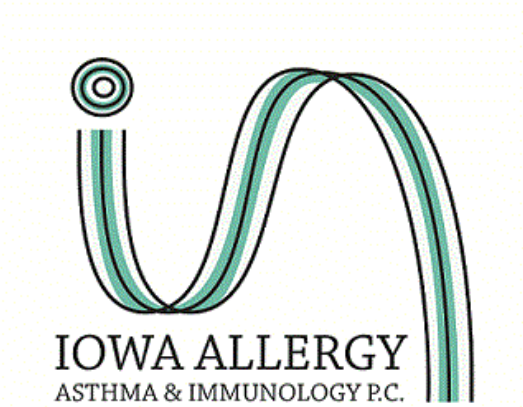

PATIENT INFORMATION

Patient Name_____ **D.O.B.**_____**Today's Date**_____

Reason for visit _____

_____

What are your symptoms worsened by?

- ☐ Cats
- ☐ Dogs
- ☐ Trees
- ☐ Grass
- ☐ Mold
- ☐ Food
- ☐ Perfume
- ☐ Smoke
- ☐ Stress
- ☐ Colds / URI
- ☐ Weather/temperature changes
- ☐ Indoor
- ☐ Outdoor
- ☐ Work

When do your symptoms occur?

- ☐ **Sp**ring
- ☐ **Su**mmer
- ☐ **Fa**ll
- ☐ **Wi**nter

Worst during: Sp Su Fa Wi

Have you been tested for allergies before? Yes/ No

Have you been on allergy shots before? Yes/ No

If previous allergy shots, how long? _____

Allergic to Following Medications:_____

_____

_____

Allergic to Following Foods:_____

_____

Please list any medications you have tried before:

Medications	**Did it help?**
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No
	Yes / No

Please Turn Page Over

If you need additional space, please ask the receptionist for another piece of paper

Past Surgical History	Date

Preferred Pharmacy and Address: _____

Medications (All current medications)	Dose	Times Per Day

Family History

	Asthma	Seasonal Allergies	Food Allergies	Other (example: Cancer, stroke, etc.)
Father	Yes / No	Yes / No	Yes / No	
Mother	Yes / No	Yes / No	Yes / No	
Brother	Yes / No	Yes / No	Yes / No	
Sister	Yes / No	Yes / No	Yes / No	
Paternal Grandparents	Yes / No	Yes / No	Yes / No	
Maternal Grandparents	Yes / No	Yes / No	Yes / No	

☐ **Please check box if family history is unknown**

Past Medical History

Primary Care Provider:_____ Referring Provider: _____

__ Seasonal Allergies	__ Anxiety	__ Cancer
__ Asthma	__ Depression	__ Kidney Disease
__ Eczema	__ GERD/Reflux	__ Thyroid Disease
__ COPD	__ Heart Disease	__ Liver disease
__ Eosinophilic Esophagitis	__ High blood pressure	Other: _____
__ Recurring Ear infections	__ Diabetes	_____
__ Skin Allergies	__ IBS	_____
__ Food allergy/intolerance	__ Crohn's/UC	_____

Tobacco History

- ☐ No Tobacco Exposure
- ☐ Exposed to second hand smoke
- ☐ Current Smoker _____ Pack/day x _____ Years
- ☐ Past smoker/Quit _____ Pack/day x _____ Years

Social Profile

Occupation	**_____ Student / Full-Time / Part-Time / Unemployed**
Marital Status	**Single Married Divorced Widowed**
Children	**Yes / No If yes, how many? _____**
Exposure to Chemicals	**Yes / No If yes, what? _____**
Alcohol use	**Yes / No _____ drinks per ____ day / week**
Exercise Level	**Yes / No _____ Times Per _____ Week / Month**
Recreational Drug Use	**Yes / No Marijuana / Cocaine / Heroin / Meth / LSD / Other: _____**

Environmental Profile (Please Circle)

Animal Exposure: Are you exposed to animals? Yes / No

What type of animals? Cat(s) / Dog(s) / Other: _____

Do your pets have access to your bedroom? Yes / No

Type of Flooring: Hardwood flooring / Carpet / Other _____

Mold: Is there evidence of mold/mildew in the home/workplace? Yes / No

Housing type: House / Duplex / Apartment / Facility