



MRN: _____

Patient Name: _____

Age: _____ Date of Birth: _____ Sex: Male / Female Pregnant: Yes / No

Primary Care Dr: _____ Referring Dr: _____ Pharmacy: _____

Same as Primary Care Physician

MAIN REASON for visit: _____

Laboratory results pertaining to this referral? Yes / No Doctor's office or laboratory: _____

(Please circle other concerns to be addressed at other visits)

Allergic reaction(s)	Nasal/Sinus allergies	Eye allergies	Throat clearing	Cough	Shortness of breath
Eczema	Hives / Rash	Swelling	Heartburn	Difficulty swallowing	Trouble with exercise
Food allergies	Insect allergy	Drug allergy	Vaccine reaction	Frequent infections	Asthma

Medical History (Allergy related) Please circle **only** physician confirmed diagnoses

Anaphylaxis	Allergic rhinitis	Allergic conjunctivitis	Asthma	# Sinus infections per year _____	
Eczema	Atopic dermatitis	Urticaria	GERD (esophageal reflux)	Food allergies	Immunodeficiency
Contact dermatitis	Stinging insect allergy	Angioedema	Eosinophilic esophagitis	Drug allergy	Other: _____

Have you ever seen an allergist before? Yes / No When? _____ Dr: _____

Did you have a skin test? Yes / No When? _____

What allergy medications have you tried? _____

For skin testing: Have you stopped all allergy/reflux-antihistamines for 7 days? Yes / No

*Did you receive the Influenza vaccine this season (Sept to Apr)? **Yes / No**
 If yes, approx. date: _____
 *Would you like the flu shot today? **Yes / No**

Hospitalizations: (List dates)	Surgeries: (List dates)

Medical History:	Current Medications:	Medication Allergies:
		<input type="checkbox"/> No known drug allergies

Are you on a medication to control your high blood pressure? Yes / No If so, what is the medication? _____

Do you have heart disease? Yes / No

Family History: (mark X or indicate detail if applies) Adopted or Unknown

	Mother	Father	Siblings	Grandparent
Nasal/Sinus allergies				
Asthma				
Food allergies				
Atopic Dermatitis / Eczema				
Bee/stinging insect allergy				
Eosinophilic Esophagitis (trouble swallowing)				
Immune problems / Frequent infections				
Urticaria or Angioedema (hives or swelling)				
Autoimmune disease				
Heart disease				
Stroke				
Lung disease				
Diabetes				
Inflammatory bowel disease				
Osteoporosis				
Cancer				
Other				

Social/Environmental History:

With whom do you / child / patient primarily live: _____

Occupation / Grade in school: _____ Home/Family manager No Daycare (Stays at Home)
 Preschool Grade School Junior/Middle School High School College

Pets/Animals at home: None Cat(s) Dog(s) Rabbit(s) Guinea Pig(s) Bird(s) Horse(s) Other: _____

Does anyone inside the home smoke? Yes No

Do you smoke or are you a former smoker? Yes No

If yes, (please circle) **vape** or **cigarettes**;

Do you use Tobacco? Yes No

___ packs per day for ___ years. Quit ___ years ago.

Do you drink alcohol? Yes No

Do you use any drugs/medications recreationally? Yes No

Is there any water damage in the home? Yes No

Is there any mold inside or outside of your home? Yes No

Are there problems with pests inside the home? Yes No

If yes, specify: _____

What type of heating do you have in your home? Gas/Forced air Fireplace/Gas stove Other: _____

What type of air conditioning do you have? Central air Window units Swamp cooler None

Do you have carpeting in your home? Throughout Minimal No

Do you use feather blankets or pillows? Yes No

Any strong fragrances used in your home? Yes No

Do you (Does the patient) follow a special diet? Yes No

If yes, please describe: _____

Have you (or the patient) traveled internationally? Yes No If yes, when/where: _____

Review of Systems: Please mark any symptoms the patient has experienced recently.

Constitutional: Fever Chills Fatigue Loss of appetite Weight loss Weight gain Sleep problems

Skin: Rash Itching Hives Dryness Frequent skin infections

Eyes: Itchy eyes Red eyes Burning eyes Watery eyes Swollen eyes Visual disturbances

Ears: Itchy ears Frequent ear infections Ear tubes

Nose: Itchy nose Sneezing Runny nose Nasal congestion Nose bleeds Nasal polyps

Sinus pressure Sinus pain Frequent sinus infections

Mouth/Throat: Itchy mouth Swollen mouth Heartburn Difficulty swallowing (food stuck) Painful swallowing

Respiratory: Cough Shortness of breath Wheezing Chest tightness Exercise intolerance

Frequent pneumonias Coughing up blood

Cardiovascular: Chest pain Palpitations History of fainting High blood pressure Taking beta-blockers (ends in lol)

Gastrointestinal: Nausea Vomiting Abdominal pain Diarrhea Blood in the stool Constipation

Liver problems

Genitourinary: Kidney problems Kidney stones Frequent infections Incontinence

Musculoskeletal: Muscle pain Joint pain Joint swelling

Endocrine: Frequent urination Thirst Heat or cold intolerance

Hematologic/Oncologic: Anemia Easy bleeding or bruising Prone to blood clots History of blood transfusion

Cancer

Allergic/Immunologic: Anaphylaxis (severe allergic reaction) Stinging insect anaphylaxis Penicillin allergy

NSAID allergy Metal allergy Latex allergy Frequent infections

Neurological: Headache Migraines Seizures Learning problems Numbness/tingling in extremities

Psychiatric: Stress Depression Anxiety Behavioral problems