New Patient Health History

Patient name___________ Date of Birth___________ Today's Date___________

Please answer all questions to the best of your ability. Base your answers on your observations, not what someone has told you. Please complete the form before your appointment.

What brings you to an allergist?____
Pharmacy:____

Current
medications:____

Review of Symptoms:
Please indicate "yes" or "no" regarding your symptoms for:

		Yes	**No**
Eyes	Itching		
	Burning		
	Watering		
	Discharge		
	Swelling		
	Redness		
Ears	Itching		
	Fullness		
	Popping		
	Tubes placed		
	Frequent infections		
Nose	Watery discharge		
	Congestion		
	Itching		
	Nasal Trauma		
	Bloody Nose		

		Yes	**No**
Throat	Soreness		
	Post Nasal Drip		
	Itching of roof of mouth		
	Recurrent strep infections		
	Hoarseness		
Chest/Lungs	Cough		
	Wheeze		
	Phlegm/ mucous		
	Short of breath at rest		
	Short of breath with exercise		
	Cough blood		
	History of bronchitis		
	History of pneumonia		
	Positive TB skin test		
		Yes	No

Skin	Eczema		
	Hives		
	Swelling		

	Frequent infection, boils, impetigo		
	Latex allergy		

ASTHMA

Have you ever been intubated, on a ventilator or in the intensive care unit for your asthma?
For your asthma only:
How many times have you been:
-hospitalized?
-to the emergency room in the past 12 months?
-prescribed steroids in the past 12 months?

SEASONAL ALLERGY SYMPTOMS

At what age did your symptoms first appear, and what seasons are your symptoms present?

Symptom	age	Spring	Summer	Fall	Winter	Year Round
Wheezing						
Cough						
Nasal congestion						
Eye trouble						
Hives						
Eczema						
Other_________						

What worsens your symptoms? ____

ENVIRONMENT

How long have you lived in the Pacific NW?
Prior states?
Type and age of home?
Location in city, suburb or rural?
Basement? Dry Damp

SOCIAL HISTORY

What soaps do you use?
Are you exposed to secondhand smoke?
Do you smoke?______ If “Yes” how many packs per day, for how many years?____________
Do you drink alcohol?____ If yes, how many & what type of drinks per day or week?_________
Do you use recreational substances? If Yes, what?

Are you:
Married Single Divorced Widowed

ANIMALS

Do you have pets? If Yes, what type?
How long have your pets lived with you?
Do you sleep with the pet?
Does the pet have access to the entire home?
Do you think that pets make your symptoms worse?

BEDROOM

How old is your mattress?
What type of mattress is it?
How old are your pillows?
What materials are your pillows made from? Feather, foam, synthetic, other, unknown

INSECT ALLERGY

After a bee sting, do you have excessive swelling?
Local or scattered hives?
Tongue or lip swelling?
Other swelling?
Shortness of breath?

DRUG OR MEDICATION ALLERGIES

What medications are you allergic to?
When did the reaction occur & what was your reaction?

Are you interested in a medication challenge?

HEALTH HISTORY

Do you have, or have your ever had:

High blood pressure
Heart disease
Irregular heart beat
Uncontrolled bleeding
Cancer
Chicken Pox
Chronic diarrhea
Diabetes
Thyroid disease
Liver disease
Kidney disease
Arthritis
Heartburn
Other

SURGERIES:
____

HOSPITALIZATIONS:
____

IMMUNIZATIONS

Childhood__________

Hepatitis B__________
Tetanus/Diphtheria___
Pneumovax__________
Prevnar 13 or 20_____
Shingrix_____________

FAMILY HISTORY

Does your mother, father, brother or sister or children have any of the following:
Hayfever/seasonal allergies
Sinus problems
Asthma
Frequent bronchitis
Eczema
Hives
Migraine headaches
Thyroid disease
Food allergies
Other