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PATIENT ALLERGY HISTORY:

PATIENT NAME: _____ DOB: _____

TODAY'S DATE: _____

THE REASON I AM SEEING THE DOCTOR TODAY IS: _____

_____

OTHER MEDICAL PROBLEMS: _____

_____

_____

PRIOR SURGERIES: _____

_____

MEDICATIONS (PRESCRIPTION, OVER THE COUNTER, VITAMINS, HERBAL): _____

_____

_____

DRUG ALLERGY? [ ] NO [ ] YES (What drug? When? Describe reaction) _____

_____

FOOD ALLERGY? [ ] NO [ ] YES (List foods, Describe reactions) _____

_____

SMOKING: [ ] NEVER [ ] YES, CURRENT [ ] YES, PAST _____

SIGNIFICANT EXPOSURE TO SECONDHAND CIGARETTE SMOKE? [ ] NO [ ] YES _____

IMMUNIZATIONS: NORMAL CHILDHOOD IMMUNIZATIONS [ ] NO [ ] YES [ ] ANNUAL FLU SHOT [ ] PNEUMOVAX

WHAT TYPE OF PETS DO YOU HAVE AT HOME?_____

OTHER PET EXPOSURES:_____

WHO IN YOUR IMMEDIATE FAMILY HAS ALLERGIES OR ASTHMA:_____

PRIOR ALLERGY TESTING? [ ] NO [ ] YES PRIOR ALLERGY SHOTS? [ ] NO [ ] YES _____

_____

Review of systems: If you experience any of the symptoms listed below, please circle

General:	Fever, Sweats, Fatigue, Change in weight
Skin:	Rash, Itching, Dry skin
Head:	Dizziness, Headaches
Eyes:	Change in vision, Red eyes, Itching, Irritation, Discharge, Cataracts
Ears:	Difficulty hearing, Ringing, Pressure, Popping, Pain
Nose:	Stuffy nose, Sneezing, Itching, Dripping, Decreased smell, Snoring
Throat:	Hoarse voice, Sore throat
Neck:	Thyroid problem, Lumps or "swollen glands"
Chest:	Pain, Shortness of breath, Cough, Wheeze, Chest tightness or heaviness
Heart:	Pain, Palpitations, Heart murmur, History of heart attack
GI:	Decreased appetite, Nausea, Vomitting, Diarrhea, Heartburn, Abdominal pain
Rheum:	Joint pain, Joint stiffness, Arthritis, Back problems
Neurologic:	History of stroke, Loss of memory, Psychiatric disorder, Numbness, Weakness
Heme/Onc:	History of anemia, History of cancer