Mainland Allergy Clinic

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Name _____ Date _____
Regular Doctor _____ Who Referred _____
Reason for visit _____
Chief Complaint _____
History of Present Illness _____
Do you have an Advanced Care Plan or surrogate decision maker? _____
If so, who? _____ Would you like for us to keep this information on file? _____

Have you ever seen an allergist? ____ If so, who & when? _____
Have you had allergy testing? _____ What are you allergic to? _____
Did you take allergy injections? _____ How long? _____ Did they help? _____
Did you have any reactions to the injections? ___ If so, what? _____
Current medications: _____
_____
Current or recent **Drops, Sprays, or Over–the-Counter Medications**: _____
_____
Allergies to medications: (include any OTC or herbal remedies) _____
_____
Circle **triggers** of your symptoms: infection, pollens, molds, dust, cat, dog, cockroaches, tobacco smoke, wood smoke, strong odors, fragrance, sprays, exercise, change in weather, newsprint, food (what) _____, other : _____
Circle when your symptoms are the worst: spring, summer, fall, winter, all year, morning, afternoon, night, other: _____
For asthma patients
What problems have you been experiencing? _____
How long? _____
Circle any problems you have: shortness of breath at rest, shortness of breath with exercise, cough, cough at night, wheeze, sputum production, chest tightness, recent rhinitis, recent sinusitis.
With asthma: (circle) have you had to make ER visit (s), been hospitalized, been intubated, missed school or work days, had limited activities, awoken at night with asthma?
Do you use your rescue inhaler (albuterol/Ventolin/Proventil) more than twice a week during the day? _____ Do you use it during the night? _____ Do you use this medicine as needed or scheduled? _____ Do you have a nebulizer?_____ How often do you use it?

_____ Do you take Theophylline?_____Please list your asthma medications: _____

Past Medical History:

Medical Diagnoses _____
Operations _____
Hospitalizations _____
Emergency Room visits _____
Blood Transfusions _____

Family History:

Which relatives have allergies? _____ sinus issues? _____
Who has asthma? _____
Who has eczema, hives or allergic skin problems? _____
What else "runs" in the family? _____

Social History:

What is your occupation? _____ Indoors __ Outdoors __
Married _____ Single _____ Other (eg:committed relationship) _____ Children _____

Do you currently **smoke**? _____ What? _____
If cigarettes, how many packs per day? _____ Did you ever smoke? _____
How many years did you smoke? _____ What year did you quit? _____
Why did you quit? _____ What technique did you use to quit? _____
Do you use e-cigarettes or vapes? _____ How often? _____
Do you drink **alcohol**? _____ If yes, what type? _____
How much do you drink daily or weekly? _____

Environment:

What kind of home do you live in? House, apartment, trailer home, other _____
How old is your home? _____ Central air? Central heat? Window units? Ceiling fans Used? Fireplace used? Do you have pets? ___ If yes, what animals do you have? _____ _____ Is the home partially carpeted? Y or N Any structural problems with the Home? Y or N If yes, what kind of problems? _____
What kind of mattress do you sleep on? (waterbed, regular, other) _____
What kind of pillow do you have? (foam rubber, feather, washable, other) _____
Any environmental controls used in the home (HEPA filter, dust mite covers) _____
_____
Any smokers in the home? Y or N If yes, who? _____
Briefly describe any other dwellings that you spend time (for example: a vacation home, school, work place, relative) _____
_____
_____

Review of Systems: (Please circle what you **have now** or have experienced **RECENTLY**)

General: loss of appetite, chills, fatigue, fever, malaise, sweats, weight loss, weight gain

Ear/Nose/Throat: ear pain or discharge, decreased hearing, nosebleeds, hoarseness, difficulty swallowing, tinnitus (ear ringing), nasal congestion, nasal discharge, sore throat, sinus pain

Eyes: blurry vision, double vision, eye discharge, eye pain, irritation, light bothering the eyes, loss of vision, floaters

Respiratory: cough, shortness of breath, excessive sputum, coughing up blood, wheezing, painful breathing, sleeping disorder, snoring

Cardiovascular: chest pain, palpitations, passing out or fainting, shortness of breath with exertion, needing to sleep with 2 or more pillows under your head, shortness of breath at night, ankle swelling, chest tightness

Gastrointestinal: belly pain, constipation, blood in stool, jaundice (yellow of skin & eyes), dark stool, nausea, vomiting, change in bowel habits, diarrhea, fatty food intolerance, heartburn, hemorrhoids, indigestion, loss of appetite, acid reflux

Genitourinary: decreased libido, pain with urination, blood in urine, difficulty with urine stream, impotence, loss of bladder control, frequent urination during the night, genital discharge, genital sores

Musculoskeletal: arthritis, back pain, joint pain, joint swelling, muscle cramps, muscle weakness, stiffness, leg cramps

Skin: dryness, itching, rash, suspicious or worrisome lesions

Neurologic: sensation changes, seizures, fainting spells, paralysis, tremor, vertigo (dizziness with the room spinning), weakness, headache

Psychiatric: anxiety, depression, hallucination, memory loss, mental disturbance, paranoia, suicidal ideation, panic attack

Endocrine: cold intolerance, heat intolerance, excess thirst, excess hunger, weight changes, abnormal sweating, excessive hair

Heme/Lymphatic: abnormal bruising, bleeding, enlarged lymph nodes, anemia, bleeding gums, lethargy, nausea, vomiting

Allergic/Immunologic: hay fever, HIV exposure, persistent infections, hives, unusual fatigue, frequent colds