

## NEW PATIENT HISTORY

**Name:** \_\_\_\_\_ **Dob:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Name & Address of Referring MD:** \_\_\_\_\_

**What are you being seen for today?** (When did symptoms start? How frequent? What makes them worse or better?)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Name of Medication	Dosage	Frequency	Date Started

**Have you ever see an allergist?** \_\_\_\_\_ **Doctor's name:** \_\_\_\_\_

**Were you on allergy shots?** \_\_\_\_\_ **When?** \_\_\_\_\_ **How long?** \_\_\_\_\_

**Family History** Please fill in the family member's initials as they apply.

**Key:** Mother: M, Father: F, Brother: B, Sister: S,  
 Maternal Grandmother: MGM, Maternal Grandfather: MGF,  
 Paternal Grandmother: PGM, Paternal Grandfather: PGF

Adopted limited history		Food Allergy	
Allergic Rhinitis/Hayfever		Acid reflux or other GI problems	
Anaphylaxis		Headaches/Migraine	
Arthritis		Hives or Swelling	
Asthma		High blood pressure	
Autoimmune disorders		Immune deficiency	
Cancer		Latex allergy	
Celiac Disease		Lung problems/COPD	
Heart disease		Seizures	
Cystic fibrosis		Sinus infections	
Dermatitis/Eczema		Thyroid disease	
Diabetes			
Drug Allergy			
Eosinophilic esophagitis			

**Patient's Past Medical History**

Allergic rhinitis	Cardiovascular problems	Neurological disorder
Anaphylactic reaction	GERD / Reflux	Pneumonia
Asthma	Headaches	Respiratory condition
Bronchitis	Psychiatric problems	RSV
Chickenpox	Hospitalization	Sinus conditions
COPD	Hypertension	Skin problems
Eczema	Immunological disorder	Sleep apnea
Endocrine problems	Kidney problems	Stomach or bowel problems
Eye conditions	Murmur	Throat conditions
Frequent colds	Musculoskeletal problems	Immunizations up to date
Frequent ear infections	Nasal conditions	Usual childhood illnesses

**Patient's Past Surgical History**

Adenoidectomy	PE Tubes	Tonsillectomy
Appendectomy	Sinus Surgery	Other (explain)

**Review Of Systems** (Please check/circle all that apply to you in the last few months)

Anemia	Endocrine-related symptoms	Joint /musculoskeletal symptoms
Asthma	Environmental allergies	Disease of lymph nodes
Breathing difficulties	Ear or nose symptoms	Neurological symptoms
Heart problems/Murmur	Eye or vision problems	Psychiatric /emotional difficulties
High Blood Pressure	Gastrointestinal symptoms	Skin-related symptoms
Fever, headache, nausea, dizziness	Heartburn	Mouth or throat symptoms
Eczema	Headache	Itchy Rash

**Chest Symptoms** (check any/all that apply)

Cough	Chest congestion	Emergency room visit for asthma?
Wheeze	Diagnosis of asthma	Steroid pills or shots for breathing?
Shortness of breath	Pneumonia	Hospitalization for asthma?
Tightness in chest	Ever use inhalers?	Missed school/work due to asthma

**Social History**

Patient is a child \_\_\_\_\_ (Circle any that apply) Daycare School Home School  
 Marital status (circle) Married Divorced Separated Single  
 Living Status (if child, circle); lives with: Family Mother Father Joint custody  
 Occupation: \_\_\_\_\_ Hobbies/Sports: \_\_\_\_\_  
 Tobacco exposure (circle): Current smoker Past smoker Exposure to tobacco in the home

**Environmental History:**

Current Home (circle): House Apartment Mobile home Duration of residence: \_\_\_\_\_  
 Home setting (circle): Farm Rural Suburban Urban/City  
 Flooring (circle all that apply): Carpet Tile Wood  
 Air Conditioning (circle): Central A/C Swamp cooler Wall unit Wood stove  
 What type of pets do you have \_\_\_\_\_ Pets in the bedroom? \_\_\_\_\_  
 Do you spend a lot of time in another house? Describe: \_\_\_\_\_  
 Any other concerns about your home? \_\_\_\_\_

**Allergic reactions**

**Describe reaction (Medications, foods, insects)**
