Name:

Allergy / Asthma History

1. Have you ever had a reaction or allergy to any drug or medication? Y N
   What specifically happened?________________________________

2. Do you have any food allergies or have you had any in the past? Y N
   What foods & symptoms:________________________________

3. Do you have any environmental allergies? (hay fever, chemicals, dust, animals, etc.) Y N
   What allergen & symptoms:________________________________

4. When did allergy and/or asthma symptoms begin? (please specify date)________________________________

   When do symptoms occur? (please circle months)

Jan	Feb	Mar	Apr	May	Jun
Jul	Aug	Sep	Oct	Nov	Dec

5. Which of the following appear to cause allergy and/or asthma symptoms? (please circle)

Animals:	Horse Cat	Dog Cattle	Rabbits	Other________________		
Odors:	Christmas trees	Detergents	Soaps	Tobacco smoke	Hairspray	
	Paint fumes	Cosmetics & perfumes		Other________________		
Pollen:	Trees Weeds	Grasses Molds				
Other:	Temp. changes	Menses(period)	Exertion	Air conditioning	Excitement	Infections
	Windy days	Laughing	Tension	Fatigue	Dampness	Aspirin

6. Current or past treatments for allergy/asthma, including dates (please include allergy injections).

   ____

   ____

7. Emergency room visits and/or hospitalizations for allergy/asthma during the past year?

   ____

   ____

8. How much work or school has been missed in the past year because of allergy and/or asthma?

   ____

   ____

9. Are there any diseases that run in your family? If so, please describe:

   ____

   ____

10. Please list any additional medical information (surgery, serious illnesses, diagnoses or hospitalizations):

   ____

   ____

Recreational Drug History

Tobacco Use:	❑ Past	❑ Present	Form:________________	❑ None
Alcohol Use:	❑ Past	❑ Present	Frequency:________________	❑ None
Illicit Drug Use:	❑ Past	❑ Present	Type:________________	❑ None

Current Medications

Please list all the medications you are using, including any Rx drugs, over-the-counter medications, supplements, vitamins, pain relievers, and any medications used "as needed".

Medication	Current dose	Start date	Date last used	Reason for use

Additional comments or information:

____

____

____

____

____

Review of Systems

Please check all areas that apply to you, remember to include dates and "ongoing or resolved".

Each Heading should have at least one check. ☑

HEAD
- ☐TMJ__________ONGOING ~ RESOLVED
- ☐SINUS PROBS__________ONGOING ~ RESOLVED
- ☐HEADACHE__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

EYES
- ☐ITCHING__________ONGOING ~ RESOLVED
- ☐BLURRY VISION__________ONGOING ~ RESOLVED
- ☐GLAUCOMA__________ONGOING ~ RESOLVED
- ☐REDNESS__________ONGOING ~ RESOLVED
- ☐TEARING__________ONGOING ~ RESOLVED
- ☐FARSIGHTED__________ONGOING ~ RESOLVED
- ☐NEARSIGHTED__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

EARS
- ☐DISCHARGE__________ONGOING ~ RESOLVED
- ☐HEARING LOSS__________ONGOING ~ RESOLVED
- ☐EAR ACHES__________ONGOING ~ RESOLVED
- ☐FREQUENT INFECTIONS___ONGOING ~ RESOLVED
- ☐ITCHING__________ONGOING ~ RESOLVED
- ☐BLOCKAGE__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

NOSE
- ☐POLYPS__________ONGOING ~ RESOLVED
- ☐HAYFEVER__________ONGOING ~ RESOLVED
- ☐CONGESTION__________ONGOING ~ RESOLVED
- ☐RUNNY NOSE__________ONGOING ~ RESOLVED
- ☐BLEEDING__________ONGOING ~ RESOLVED
- ☐SNEEZING__________ONGOING ~ RESOLVED
- ☐LOSS OF SMELL__________ONGOING ~ RESOLVED
- ☐ITCHING__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

THROAT
- ☐ITCHING__________ONGOING ~ RESOLVED
- ☐POST NASAL DRIP__________ONGOING ~ RESOLVED
- ☐BAD BREATH__________ONGOING ~ RESOLVED
- ☐HOARSENESS__________ONGOING ~ RESOLVED
- ☐SORE__________ONGOING ~ RESOLVED
- ☐VOICE LOSS__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

ENDOCRINE
- ☐THYROID __________ONGOING ~ RESOLVED
- ☐DIABETES __________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

BREASTS
- ☐DISCHARGE__________ONGOING ~ RESOLVED
- ☐SORENESS__________ONGOING ~ RESOLVED
- ☐LUMPS/CYST__________ONGOING ~ RESOLVED
- ☐MALIGNANCIES__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

HEART / VASCULAR
- ☐HEART ATTACK__________ONGOING ~ RESOLVED
- ☐HI BLOOD PRESSURE__________ONGOING ~ RESOLVED
- ☐MURMUR__________ONGOING ~ RESOLVED
- ☐ABNORMAL BEAT__________ONGOING ~ RESOLVED
- ☐VASCULAR DISEASE__________ONGOING ~ RESOLVED
- ☐ANGINA__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

LUNGS
- ☐ASTHMA__________ONGOING ~ RESOLVED
- ☐BRONCHITIS__________ONGOING ~ RESOLVED
- ☐PNEUMONIA__________ONGOING ~ RESOLVED
- ☐EMPHYSEMA__________ONGOING ~ RESOLVED
- ☐CYSTIC FIBROSIS__________ONGOING ~ RESOLVED
- ☐CHEST TIGHTNESS__________ONGOING ~ RESOLVED
- ☐WHEEZING__________ONGOING ~ RESOLVED
- ☐COUGH__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

LIVER
- ☐HEPATITIS__________ONGOING ~ RESOLVED
- ☐GILBERT'S SYNDROME__________ONGOING ~ RESOLVED
- ☐GALL STONES__________ONGOING ~ RESOLVED
- ☐TUMORS__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

KIDNEY
- ☐KIDNEY STONES__________ONGOING ~ RESOLVED
- ☐CYSTS__________ONGOING ~ RESOLVED
- ☐FREQUENT INF. __________ONGOING ~ RESOLVED
- ☐GLOMERULONEPHRITIS___ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

STOMACH / DIGESTION
- ☐ULCERS__________ONGOING ~ RESOLVED
- ☐HEARTBURN__________ONGOING ~ RESOLVED
- ☐CONSTIPATION__________ONGOING ~ RESOLVED
- ☐DIARRHEA__________ONGOING ~ RESOLVED
- ☐LOSS OF APPETITE__________ONGOING ~ RESOLVED
- ☐NAUSEA/VOMITING __________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

GENITOURINARY
- ☐UTERINE/CERVICAL CANCER__________ONGOING~ RESOLVED
- ☐OVARIAN CYSTS__________ONGOING ~ RESOLVED
- ☐ULCERS__________ONGOING ~ RESOLVED
- ☐FREQUENT INF__________ONGOING ~ RESOLVED
- ☐PROSTATE CANCER__________ONGOING ~ RESOLVED
- ☐PROSTATE ENLARGEMENT__________ONGOING ~ RESOLVED
- ☐MENSTRUAL CRAMPS__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

MUSCULOSKELETAL
- ☐RHEUMATOID ARTHRITIS__________ONGOING ~ RESOLVED
- ☐OSTEOARTHRITIS__________ONGOING ~ RESOLVED
- ☐JOINT REPLACEMENT__________ONGOING ~ RESOLVED
- ☐BROKEN BONES__________ONGOING ~ RESOLVED
- ☐OSTEOPOROSIS__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

NEUROLOGIC
- ☐MIGRAINES__________ONGOING ~ RESOLVED
- ☐SEIZURES__________ONGOING ~ RESOLVED
- ☐PARKINSON'S__________ONGOING ~ RESOLVED
- ☐FREQUENT INF__________ONGOING ~ RESOLVED
- ☐MULTIPLE SCLEROSIS__________ONGOING ~ RESOLVED
- ☐NUMBNESS__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

PSYCHIATRIC
- ☐DEPRESSION__________ONGOING ~ RESOLVED
- ☐ANXIETY__________ONGOING ~ RESOLVED
- ☐ALCOHOL ABUSE__________ONGOING ~ RESOLVED
- ☐ALZHEIMER'S__________ONGOING ~ RESOLVED
- ☐BI-POLAR DISORDER__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

HEMATOLOGY / IMMUNE
- ☐ANEMIA__________ONGOING ~ RESOLVED
- ☐LEUKEMIA__________ONGOING ~ RESOLVED
- ☐LUPUS__________ONGOING ~ RESOLVED
- ☐ALLERGIES__________ONGOING ~ RESOLVED
- ☐AIDS__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

SKIN
- ☐HIVES __________ONGOING ~ RESOLVED
- ☐ECZEMA__________ONGOING ~ RESOLVED
- ☐ACNE__________ONGOING ~ RESOLVED
- ☐PSORIASIS__________ONGOING ~ RESOLVED
- ☐CANCER__________ONGOING ~ RESOLVED
- ☐ITCHING/DRY__________ONGOING ~ RESOLVED
- ☐INFECTION__________ONGOING ~ RESOLVED
- ☐OTHER__________
- ☐NONE

My signature indicates that this medical history is accurate to the best of my knowledge.

Signature__________________________________ Date__________________

(Parent or Insured if Minor)

Doctor's Signature__________________________________ Date__________________