Mary Parkes Center for Asthma, Allergy & Pulmonary Care

_____ _____ _____
(Name) (Date of Birth) (Date)

Please answer a few questions about your health and bring this form with you at the time of your visit.

Reason for allergy consultation today: _____
_____
_____

Have you ever had an allergy evaluation? No Yes If yes, When / Where_____
Have you ever been on allergy shots? No Yes If yes, When / Where and for how long._____
_____

Past medical and allergic problems include:
1. _____
2._____
3. _____
4. _____
5. _____

Past surgical procedures include:
1. _____
2. _____
3. _____
4. _____
5. _____

Home Environment: Apartment House *(Circle all that apply)*
Pets Yes Type_____ No Air Conditioning Forced Air Heating Radiator
Access to Bedroom Yes No Gas Heat Electric Heat
Mold in the home Yes No

List all current medications (*please include dosage and bring the prescription bottles and inhalers with you at the time of the visit*). If you already have a current medication list you can bring that to the visit.
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Name and telephone of Pharmacy used: _____

Are you allergic to any medications *(please circle)*? Yes No
If yes, please list. _____

Please describe if you have had the following allergic reactions and describe the type of reaction:
Foods _____
Medication _____
Seasonal _____
Latex _____ Insects _____

The following diseases have occurred in my immediate family members (grandparents, parents, brothers sisters and children): _____
_____
_____

Do you smoke *(please circle)*? No Yes If yes, # of years smoked? _____
Have you ever smoked ? No Yes When did you quit? _____ # years smoked _____
Are you or your child exposed to 2nd hand tobacco exposure? Yes No
Do you drink alcohol? No Yes If yes, how much do you drink? Daily _____Weekly _____

Child: Name of school. _____ Grade level _____
Adult : Describe occupation and work environment: _____
Social History: Married Single Separated Divorced
Children: Yes # of children_____ No

Please circle whether or not you have had any of the following problems:

GENERAL

Weight Loss Gain _____Amount in pounds

Fatigue	Yes	No
Weakness	Yes	No
Fever/Chills	Yes	No
Night Sweats	Yes	No
Tremors	Yes	No

PULMONARY

Short of Breath	Yes	No
Wheezing	Yes	No
Cough	Yes	No
Blood in Sputum	Yes	No
Pneumonia	Yes	No
Asthma	Yes	No
Emphysema	Yes	No
Tuberculosis	Yes	No
Bronchitis	Yes	No

GASTROINTESTIONAL

Change in Appetite	Yes	No
Nausea / Vomiting	Yes	No
Diarrhea	Yes	No
Abdominal Pain	Yes	No
Burping / Belching	Yes	No
Morning Throat		
Hoarseness	Yes	No
Ulcer	Yes	No
Hiatal Hernia	Yes	No
Heartburn	Yes	No
Diverticulitis	Yes	No
Hepatitis	Yes	No
Pancreatitis	Yes	No

VASCULAR

Calf Pain w / walking	Yes	No
Phlebitis	Yes	No

MUSCULOSKELETAL

Gout	Yes	No
Arthritis	Yes	No

DERMATOLOGIC

Eczema	Yes	No
Hives	Yes	No
Itching	Yes	No
Red Rash	Yes	No

HEAD, EYES, EARS, NOSE, THROAT

Headaches	Yes	No
Blurred Vision	Yes	No
Cataracts	Yes	No
Glaucoma	Yes	No
Buzzing in Ear	Yes	No
Hearing Loss	Yes	No
Dizziness	Yes	No
Sinusitis	Yes	No
Nose Bleeds	Yes	No
Sore Throat	Yes	No
Dentures	Yes	No
Snoring	Yes	No
Decreased Smell	Yes	No
AM Throat Clearing	Yes	No

CARDIAC

Hypertension	Yes	No
Murmur	Yes	No
Chest Pain	Yes	No
Palpitations	Yes	No
Swelling / Legs	Yes	No

GENITOURINARY

Pain on Urination	Yes	No
Frequency of Urination	Yes	No
Urination at Night	Yes	No
Incontinence	Yes	No
Kidney Stones	Yes	No

NEUROLOGICAL

Numbness / Tingling	Yes	No
Loss of consciousness	Yes	No

ENDOCRINE

Diabetes	Yes	No
Thyroid	Yes	No

HEMATOLOGIC

Anemia	Yes	No
Lymph Node Enlargement	Yes	No

PSYCHIATRIC

Anxiety	Yes	No
Depression	Yes	No

Please include any additional comments:

_____
_____
_____
_____
_____