Allergy Sinus & Arthritis Clinic. PLLC

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Allergy New Patient Information

Patient name: Date of Birth:

Pharmacy Name: Location: Phone:

Drug Allergies:

Referring Physician Requesting Consultation:

Primary Care Physician or Nurse Practitioner:

Reason for Visit:

Previous Allergist Name: Last Office Visit date:

Previous skin tests (including food): Yes/ No. If yes, when: __________ where: forearm/back

Previous allergy shots: Yes/ No. If yes, for how long: ________ Helpful/not____________

Present History: Symptoms ____

____

Worst two symptoms: ____

When did your symptoms start (circle the symptomatic months): **Jan/ Feb/ Mar/ Apr/ May/ June/ July/ Aug/ Sep/ Oct/ Nov/ Dec/ All Year round** **Spring Summer Fall Winter All year round**

Frequency of symptoms: everyday/ seasonal Which season is worse: _________________

Previous diagnosis of allergy rhinitis or hay fever? Yes/ No. If yes, when: ___________________

Nasal polyps: Yes/ No. If yes, polyps removal surgery: Yes/ No When:_____________

Hx of snoring: Yes/ No. Are you a mouth breather? Yes/ No Use CPAP machine: Yes/ No

Regular use of Aspirin/ NSAIDS (Aleeve: Naproxen)/ Advil/ Motrin (Ibuprofen): Yes/ No ___________

Hx of reactions with food: Yes/ No. If yes, which:_________________ Reaction: ____________

Hx of hives or angioedema (swelling) or both: _________________

Hx of drug reactions/allergies: Yes/ No. If yes, which: _______________ Reaction: _____________

Allergy Medications History:

Oral allergy medication (past and current)____

Nose spray use (Past and current)____

Nosebleed with nose spray: Yes / No. Use of saline nose spray/ gel (ocean spray/ Ayr saline gel) or Vaseline for dry nose: Yes/ No. Use of sinus rinses: Yes/ No. If yes, how often: _____________ Tape water or distilled water: __________ Helpful/not: ______________

Eye drops use (Past and Current):____

Recent Prednisone use (last 6 months): Yes/ No. If yes, why:_____________ when:_________ **Hygiene Components:** Soap: __________________ Shampoo: _______________ Conditioner: ___________________Detergent: _____________________ Fabric softener: ____________________ Perfumes: ______________ Toothpaste: ____________ Cosmetics:_____________________ Any recent changes: ___________________________

Please select any family members who have the following illnesses:

	Mother	Father	Sister(s)	Brother (s)	Children	Other
Allergies	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Eczema or other rashes	☐	☐	☐	☐	☐	☐
Swelling (Angioedema)	☐	☐	☐	☐	☐	☐
Immune Deficiency	☐	☐	☐	☐	☐	☐
Autoimmune Disease	☐	☐	☐	☐	☐	☐

Smoking history: Cig packs per day:_________________ Years of smoking hx: _________

When did you quit:_______ Years of smoking hx:_________ Exposure to second hand smoke at home: _______________
Never smoked: ______________

History of Alcohol use: Yes / No. None/ 0-2 drinks per day/ 2+ drinks per day/ occasionally

History of Substance abuse: Yes/ No. If yes, which: Marijuana /Cocaine /Crack/ Amphetamines/ Opiates

Occupation (current): __________ If retired, previous occupation: ______________ **Hobbies:** ____________________________________

Personal Medical History:____

Surgical Procedure: (Circle): Nose septoplasty/ Sinus surgery (when: _________How many:__________)/ Nasal polyps surgery/ Tonsillectomy/ Adenoidectomy/ History of nose trauma/ Lung surgery, Ear tubes (when: __________________)

Personal history of previous malignancies: ____

Immunization History:

Flu	Year:
Pneumovax	Year:
Prevnar	Year:
Tetanus	Year:

Reactions to vaccination: Yes/ No. Which:__________________ Year: _____ Reaction:_______________________
Age related cancer screening up-to-date: Colonoscopy (Date: ________, normal/abnormal), Mammogram (Date:_________ normal/abnormal), Pap smear (Date______, normal or abnormal)
Contraception use: Yes/No, If yes, Start Date:_______________
*Do you have any mold issues in your home? Yes No
*Are there any workplace exposures, hobbies or recreational activities that worsen your symptoms? Yes No
If yes, please specify:____
*Any Pets at home? (Dog, Cat, Birds, mice, guinea pigs, Rabbits etc.____________________)