Patient Name: ______________________ Patient DOB: ___/___/______ Date: ___/___/______

PATIENT HISTORY

Medical Conditions

Condition	YES	NO
High blood pressure	☐ YES	☐ NO
Heart Disease	☐ YES	☐ NO
COPD/Chronic Bronchitis	☐ YES	☐ NO
Uncontrolled Asthma	☐ YES	☐ NO
Stroke	☐ YES	☐ NO
Immune Disorders (HIV, rheumatoid arthritis, cancer, etc.)	☐ YES	☐ NO

Additional Information

Are you pregnant? ☐ YES ☐ NO ☐ N/A

Do you have the skin condition called ***dermographism***? ☐ YES ☐ NO

Have you ever had a severe anaphylactic (allergic) reaction that required emergency medical attention? ☐ YES ☐ NO If yes, explain: ______________________

List **all current medications,** including prescribed and OTC medications:

NAME	TAKEN FOR	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Allergy History

When did allergies begin? (Year) ____________

Do symptoms include itching and sneezing? ☐ YES ☐ NO

When do symptoms occur? (check all that apply)

☐ All months

☐ January ☐ April ☐ July ☐ October

☐ February ☐ May ☐ August ☐ November

☐ March ☐ June ☐ September ☐ December

When are symptoms worse?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

☐ At home ☐ At work ☐ At school ☐ Other location: ________

Symptoms are: ☐ Constant ☐ Occasional ☐ Rare

Symptoms interfere with activities:

☐ Not at all ☐ Mildly ☐ Moderately ☐ All the time

Which of the following cause or make symptoms worse? (Check all that apply)

FOOD

☐ Meat ☐ Wine ☐ Mushrooms ☐ Milk / milk products ☐ Fruit juices

☐ Beer ☐ Cheese ☐ Poultry ☐ Fish ☐ Wheat products

☐ Nuts ☐ Chicken ☐ Vinegar ☐ Eggs/egg products ☐ Vegetables

☐ Liquors ☐ Other: (list all) ______________________

Patient Name: ______________________ Patient DOB: ___/___/___ Date: ___/___/___

ENVIRONMENT

☐ Wind	☐ Smoke	☐ Barns/Hay	☐ High pollution	☐ Damp areas
☐ Soap	☐ Powder	☐ Mowing lawns	☐ Insecticides	☐ Dust
☐ Paint fumes	☐ Perfumes	☐ Cosmetics	☐ Newspapers	☐ Wool
☐ House plants	☐ Weather change	☐ Wet weather	☐ Dry weather	☐ Hot day
☐ Cold day	☐ Air-conditioning	☐ Travel	☐ Household plants	☐ Feather pillows
☐ Hay	☐ Cut grass	☐ Cut flowers	☐ Rugs/rug pads	☐ Christmas trees
☐ Stuffed toys	☐ Furniture	☐ Other: (list all) ______		

Indoors, explain: ______________________

Outdoors, explain: ______________________

PETS

☐ Birds ☐ Cat: Indoor / Outdoor ☐ Dog: Indoor / Outdoor ☐ Cattle ☐ Horse

☐ Other: (list) ______________________

Place **X** under self or **age** of family members with any of the following medical conditions:

Condition	Self	Father	Mother	Brothers	Sisters	Children
Migraine						
Hay Fever						
Hives						
Eczema						
Asthma						
Food Allergies						

Allergy Care History

List any OTC or Prescribed medications taken for allergy symptoms and when:

NAME	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Other

Have you (patient) had an allergy shot in the last two weeks? ☐ YES ☐ NO If yes, explain ______

Have you (patient) had any vaccine within the last 48 hours? ☐ YES ☐ NO If yes, explain ______

Do you (patient) have an allergy to latex? ☐ YES ☐ NO If yes, explain ______

Do you (patient) have an allergy to rubbing alcohol? ☐ YES ☐ NO If yes, explain ______

Do you (patient) have an allergy to any medications? ☐ YES ☐ NO If yes, explain ______

For Provider Use Only:

NOTES:

______________________ Patient/Guardian Printed Name ______________________ Patient/Guardian Signature ___/___/___ Date

______________________ Provider Printed Name ______________________ Provider Signature ___/___/___ Date