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PATIENT'S INTAKE FORM - ADULT > 14 years old

DATE: \_\_\_\_\_

**REASON FOR EVALUATION TODAY? :** \_\_\_\_\_

Describe briefly your most bothersome symptoms, their duration, severity, and previous therapies:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you had allergy testing done?  No,  Yes If so, **What year, office and doctor?** \_\_\_\_\_

Have you had allergy shots:  No,  Yes. If so, **What time frame?** From \_\_\_\_\_ to \_\_\_\_\_

Do you have Asthma?  No,  Not certain,  Yes If so, **What year was your last lung function test?** \_\_\_\_\_

**ALLERGY TESTING OPTIONS:** (Please write your initials, by your choice)

\_\_\_\_\_ I prefer to meet first with a physician to decide what testing, if any, is advised.

\_\_\_\_\_ In order to expedite my allergy evaluation, I prefer to commence with allergy skin prick testing before meeting with my doctor. I have been able to withhold taking any antihistamine medications for the past seven days. Additionally, I understand that the physician may still recommend further testing that may or may not be able to be completed at today's visit.

I am interested in the following for allergy skin testing (please mark any that apply):

- Complete Environmental Allergen Panel (designed for consideration for allergy shots)
- Complete Food Allergen Panel
- Allergen Screening Panel for adults and children
- Other allergy testing (Medications, Insects, Venom e.g.) list: \_\_\_\_\_

**ANTIHISTAMINE USE:**

- Yes, I have been able to withhold all antihistamine medications for the past seven days.
- No, I have not been able to withhold all antihistamine medications for the past seven day
- I would like to review a list of medications that may interfere with allergy skin testing.

**Last time an antihistamine medication taken was?** \_\_\_\_\_

**MEDICATIONS:** Please list all currently prescribed or over-the-counter Medications/Supplements; **Including any over the counter treatment for HEARTBURN or SLEEP AID.**

Name / Dose / Regimen	Daily	As needed	Name / Dose / Regimen	Daily	As needed

**Have you ever been prescribed epinephrine injector?**  No,  Yes, in the past,  Currently.

For what reason? \_\_\_\_\_

**Any allergic reactions to medications?**  No,  Yes, if what medication(s) and please describe reaction

\_\_\_\_\_



**PATIENT'S MEDICAL HISOTRY (please mark any or all that apply to the following questions)**

**Review of System**

- General:**  growth concerns;  weight loss;  weight gain;  fevers;  night sweats;  Other
- Head:**  headaches;  dizziness;  seizures;  fainting spells;  sinus pain;  Other
- Eyes:**  redness;  itching / irritation;  dry eyes;  eyelid swelling;  conjunctivitis;  Eye Pain,  Light sensitivity  
 Acute vision changes,  Other \_\_\_\_\_
- Ears / Nose / Throat:**  decreased hearing;  sneezing;  nasal drainage;  nasal congestion;  itching;  sinusitis;  
 nosebleeds;  sore throat;  snoring;  mouth sores;  Nasal sinus polyps  Other \_\_\_\_\_
- Neck:**  swollen glands;  thyroid problems;  masses;  Other \_\_\_\_\_
- Heart:**  chest pain;  high blood pressure;  irregular heartbeats;  Raynaud's;  Other \_\_\_\_\_
- Lungs:**  shortness of breath;  chest tightness;  chronic cough;  recurrent pneumonia;  Wheezing
- GI:**  heartburn / GERD;  lactose intolerance;  diarrhea;  vomiting;  abdominal pain;  Other \_\_\_\_\_
- Endocrine:**  diabetes;  heat / cold intolerance;  heavy / irregular menstrual periods;  Other \_\_\_\_\_
- Skeletal:**  joint pain;  muscle aches;  weakness;  Other \_\_\_\_\_
- Skin:**  itching;  hives;  rash;  eczema;  Other \_\_\_\_\_
- Psychiatric:**  depression;  anxiety;  mood swings;  Other \_\_\_\_\_

**Has another physician ever diagnosed patient with:**

- Asthma?  Yes  No
- Nasal Allergies?  Yes  No
- Food Allergies?  Yes  No
- Hives?  Yes  No
- Eczema?  Yes  No
- Recurrent Sinus Infections?  Yes  No
- Recurrent Ear Infections?  Yes  No
- Any other problems:  Yes  No

**Has patient ever received the following vaccination:**

- Seasonal Influenza?  Yes  No
- Pneumococcal?  Yes  No

**Has patient even had any of the following surgeries:**

- Sinus Surgery?  Yes  No
- Ear tube replacement?  Yes  No
- Tonsillectomy?  Yes  No
- Adenodectomy?  Yes  No

**Has patient ever been hospitalized for:**

- Asthma?  Yes  No
- Allergic Reaction?  Yes  No

**Has patient even been seen in ER Dept. or Ugent Care for:**

- Asthma?  Yes  No
- Allergic Reaction?  Yes  No

**Family History Do any relatives have any of the following? (fill in all that apply):**

- Father:  asthma  nasal allergies  eczema  food allergies  recurrent infections  none
- Mother:  asthma  nasal allergies  eczema  food allergies  recurrent infections  none
- Siblings:  asthma  nasal allergies  eczema  food allergies  recurrent infections  none
- Children:  asthma  nasal allergies  eczema  food allergies  recurrent infections  none

**Social History**

- Working from home or home office?  Yes  No
- Do you have any pets?  Yes  No
- Current tobacco use?  Yes  No
- Secondhand smoke exposure at home?  Yes  No
- Additional physical activity?  Yes  No
- Alcohol intake?  Yes  No
- Suspected mold or known water damage in home?  Yes  No
- Do pets access patient's bedroom?  Yes  No
- Prior tobacco use?  Yes  No
- Air purifier use?  Yes  No
- Wear contact lenses?  Yes  No
- Ever treated for alcohol dependence  Yes  No

**FOR OFFICE USE ONLY** Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Temperature: \_\_\_\_\_ BP: \_\_\_\_\_ Pulse: \_\_\_\_\_