

# Frisco Allergy & Asthma Center

Eric J. Schmitt, MD ■ Kameswari Konduri, MD

9191 Kyser Way Bldg 3, Suite A Frisco, TX 75034  
580 S. Denton Tap Rd. Ste 290 Coppell, TX 75019  
T: 972-731-5976 F: 972-731-6202  
[www.allergyfrisco.com](http://www.allergyfrisco.com)

## PATIENT'S INTAKE FORM

Today's Date: \_\_\_\_\_

Patient name: \_\_\_\_\_ Gender:  M  F DOB/age: \_\_\_\_\_  
Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Primary Physician: \_\_\_\_\_ Phone: \_\_\_\_\_  
Preferred Pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_  
How did you hear about us?  Doctor referral  Ins. Co.  Internet  Other Patient  
 Advertisement \_\_\_\_\_  Other \_\_\_\_\_

I. REASON FOR EVALUATION TODAY? : \_\_\_\_\_

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

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Previous allergy testing:  No,  Yes, year \_\_\_\_\_ by Dr. \_\_\_\_\_ located \_\_\_\_\_

Previous allergy shots:  No,  Yes, from \_\_\_\_\_ to \_\_\_\_\_

Do you have Asthma?  No,  Not certain,  Yes, if so, last lung function test was performed in year of \_\_\_\_\_

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

\_\_\_\_\_ I prefer to meet first with Dr. Schmitt or Dr. Konduri 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 Dr. Schmitt or Dr. Konduri. I have been able to withhold taking any antihistamine medications for the past seven days. Additionally, I understand that Dr. Schmitt or Dr. Konduri 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: \_\_\_\_\_

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 days.

I would like to review a list of medications that may interfere with allergy skin testing.

Last time antihistamine  
medications taken? \_\_\_\_\_

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## II. REVIEW OF SYSTEMS: (please mark any or all that apply)

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;  Other \_\_\_\_\_

Ears / Nose / Throat:  decreased hearing;  sneezing;  nasal drainage;  nasal congestion;  
 itching;  sinusitis;  nosebleeds;  sore throat;  snoring;  mouth sores;  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;  Other \_\_\_\_\_

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 \_\_\_\_\_

## III. MEDICATIONS: Please list all currently prescribed or over-the-counter Medications/Supplements:

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

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

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

Any medication allergic reactions?  No,  Yes, if so please describe \_\_\_\_\_

Do you take OTC medications for heartburn?

No,  Yes, if so please list \_\_\_\_\_

Do you take OTC medications to help with sleep?

No,  Yes, if so please list \_\_\_\_\_

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## Medical History

### Has another physician ever diagnosed patient with:

- Asthma?  No  Yes  
Nasal Allergies?  No  Yes  
Hives?  No  Yes  
Eczema?  No  Yes  
Recurrent Sinus Infections?  No  Yes  
Recurrent Ear Infections?  No  Yes  
Any other problems:  No  Yes, please list: \_\_\_\_\_

Please darken all squares completely.  
Checks, Xs, or incomplete circles may  
not be accurately read by the scanner.

### Has patient ever received the following vaccinations:

- Seasonal Influenza?  No  Yes, most recent year: \_\_\_\_\_  
H1N1 Influenza?  No  Yes, most recent year: \_\_\_\_\_  
Pneumococcal?  No  Yes, most recent year: \_\_\_\_\_

### Has patient ever had any of the following surgeries:

- Sinus Surgery?  No  Yes, year(s): \_\_\_\_\_  
Ear tube placement?  No  Yes, year(s): \_\_\_\_\_  
Tonsillectomy?  No  Yes, year: \_\_\_\_\_  
Adenoidectomy?  No  Yes, year: \_\_\_\_\_

### Has patient ever been hospitalized for:

- Asthma?  No  Yes, # of times: \_\_\_\_\_ most recent year: \_\_\_\_\_  
Allergic Reaction?  No  Yes, # of times: \_\_\_\_\_ Suspected allergen(s): \_\_\_\_\_

### Has patient ever been seen in Emergency Dept. or Urgent Care for:

- Asthma?  No  Yes, # of times: \_\_\_\_\_ most recent year: \_\_\_\_\_  
Allergic Reaction?  No  Yes, # of times: \_\_\_\_\_ Suspected allergen(s): \_\_\_\_\_

## 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 \*for a patient less than 14 years old\*

- Premature birth?  No  Yes, at \_\_\_\_\_ weeks  
 Weight at birth?  more than 7 pounds  less than 7 pounds, \_\_\_\_\_ lb. \_\_\_\_\_ oz.  
 Breastfed?  No  Yes,  up to 6 months  longer than 6 months  
 Antibiotic use under 12 months of age?  No  Yes,  less than 3 times,  more than 3 times  
 School/Day care?  not at all  part time  full time  
 Do parents or adult caregivers smoke?  No  Yes,  Mother,  Father,  Other \_\_\_\_\_  
 Suspected mold or known water damage in home?  No  Yes  
 Pets?  No  Yes, if so, please list:  
 cat(s) # \_\_\_\_\_,  dog(s) # \_\_\_\_\_,  other \_\_\_\_\_  
Do pets access patient's bedroom?  No  Yes  
 Air purifier use?  No  Yes  
 Extracurricular physical activity?  No  Yes, which sports? \_\_\_\_\_ # times per week \_\_\_\_\_