

Frisco Allergy & Asthma Center

Eric J. Schmitt, MD ■ Kameswari Konduri, MD

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T: 972-731-5976 F: 972-731-6202

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:

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 of 14 y.o. or older*

- Working from home or home office? Yes No, list work settings and job _____
 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
 Current tobacco use? No Yes, how many cigarettes per day? _____
 Prior tobacco use? No Yes, how many years? _____ Year quit? _____
 Secondhand smoke exposure at home? No Yes
 Air purifier use? No Yes
 Additional physical activity? No Yes, which sports? _____, # times per week _____
 Wear contact lenses? No Yes