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DMV
Allergy & Asthma Center

New Patient History

Name:_____ **Date of Birth:** _____

Primary Care Physician:_____
Referred by: _____
Pharmacy: _____

How did you hear about us?_____

Reason for today's visit:

_____

Current Medications(dose & frequency):

Medication Allergies/Sensitivities(list reaction):

Food Allergies/Sensitivities (list reaction):

Symptoms-*circle all that apply*

Ear, Nose, Throat: runny nose, sneezing, nasal congestion, post nasal drip, sore throat, sinus pressure/pain, throat swelling, ear aches

Eyes: itchy, watery, dry, red, swollen, drainage, dark circles, pain

Respiratory:cough, shortness of breath, wheezing, chest tightness

Skin symptoms: hives, itching, rash, dryness, eczema

Stomach: upset stomach, reflux, nausea, vomiting, diarrhea, constipation, abdominal pain

Head: migraines, chronic headaches, vertigo, dizziness

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Past Allergy & Asthma History-*circle all that apply*

Previous skin tests/blood tests/allergy shots?

Vaccinations up to date? Yes/No Any adverse reactions to vaccinations?

Asthma diagnosis? Yes/No

made how many years ago?_____ Last chest x-ray?_____ Results?

Use of an inhaler or nebulizer? Yes/No

Performed a Pulmonary Function Test? Yes/No

Stung by a bee? Yes/No

Any adverse reaction? Yes/No If yes, please describe reaction:

Medical History:

Emergency Room Visits *(date and reason):*

Days of school or work missed per year:

History of*(circle all that apply)*:

Cancer	Breast, Brain, Lung, Pancreatic, Ovarian, Prostate, Stomach, Liver, Skin, Cervical, Esophageal, Other:
Cardiac	Stroke, Hypertension, Palpitations, Murmur, Pacemaker
Eyes	Glasses, Contact lenses, Glaucoma, Blindness, Cataracts, Eye Disease
Ears	Hearing aids, Hearing loss, Chronic ear infections
Nose	Nasal polyps, Nosebleeds, Allergic rhinitis, Chronis sinusitis

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Skin	Rash, Eczema, Acne, Hair loss, Nail disorders
Musculo skeletal	Arthritis, Osteoporosis, Chronic back pain
Endocrine	Diabetes, Thyroid condition, Autoimmune disorder, Kidney disease, Renal disease, Addison's disease, Scleroderma, Lupus
Gastrointestinal	Reflux, Esophagitis, Hernia, Ulcer, Polyps, Gallbladder, Crohn's Disease, Irritable Bowel Syndrome
Urinary/Reproductive	Breast Disease, Prostate Disease, Childbirth history
Respiratory	Asthma, COPD, Chronic bronchitis, Tuberculosis, Pneumonia, Emphysema, Sleep Apnea- on CPAP?
Neurological	Epilepsy, Seizures, Chronic headaches, Migraines, Memory loss, Stroke
Psych/Social	Depression, Suicide Attempt, Anxiety, Bipolar, OCD, Insomnia

Surgical History (list date & procedure):

Family History (check all that apply):

	Asthma	Allergies	Immune Disorder	Other (list)
Father				
Mother				
Brother				
Sister				
Paternal GF				

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Paternal GM				
Maternal GF				
Maternal GM				

Social History:

Occupation: _____

Where Employed: _____

Hobbies: _____

Marital Status: Single, Married, Divorced, Separated, Widowed, Other

Number of children (NA if none): _____

Primary Residence: One home; 2 or more homes

Tobacco Use: Yes/No

How much for how long? _____ **Tobacco Exposure:** Yes/No

Alcohol Use: Yes/No

Drug Dependency: Yes/No

Pets	Number	Age	How long owned	Kept where	Bathed?	Bedroom Access?	Symptoms
Cat							
Dog							
Bird							
Rabbit							

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Hamster							
Guinea Pig							
Reptile							
Other							

Environmental History:

Type of Home:

Single Family, Townhouse, Mobile Home, Apartment, Other

Structure: Wood Frame, Brick. Age:_____ Length of Residency: _____

Heat/Cooling System: Forced Hot Air, Central Air, Window Air Conditioners, Radiators

Foundation: Basement, Crawl Space, Slab

Dehumidifier: Yes/No

Patient's Bedroom: Carpet, Hardwood, Tile, Curtains

Bedding: Feather Pillows, Foam Pillows, Standard Bed, Water Bed. Hypoallergenic Bedding: Yes/No

Plants: Number and location of plants_____

Laundry: Location of laundry room _____

Outdoor clothesline: Yes/No

Comments: