Allergy / Asthma History

1. Have you ever had a reaction or allergy to any drug or medication? Y N
   What specifically happened?___________________________________________________________________________________

2. Do you have any food allergies or have you had any in the past? Y N
   What foods & symptoms:______________________________________________________________________________________

3. Do you have any environmental allergies? (hay fever, chemicals, dust, animals, etc.) Y N
   What allergen & symptoms:____________________________________________________________________________________

4. When did allergy and/or asthma symptoms begin? (please specify date)________________________________________________
   When do symptoms occur? (please circle months)  Jan Feb Mar Apr May Jun
   Jul Aug Sep Oct Nov Dec

5. Which of the following appear to cause allergy and/or asthma symptoms? (please circle)
   Animals: Horse Cat Dog Cattle Rabbits Other______________________________
   Odors: Christmas trees Detergents Soaps Tobacco smoke Hairspray
   Paint fumes Cosmetics & perfumes Other______________________________
   Pollen: Trees Weeds Grasses Molds
   Other: Temp. changes Menses(period) Exertion Air conditioning
   Windy days Laughing Tension Fatigue Excitement
   Infections Dampness Aspirin

6. Current or past treatments for allergy/asthma, including dates (please include allergy injections).
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

7. Emergency room visits and/or hospitalizations for allergy/asthma during the past year?
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

8. How much work or school has been missed in the past year because of allergy and/or asthma?
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

9. Are there any diseases that run in your family? If so, please describe:
   __________________________________________________________________________________________________________
   __________________________________________________________________________________________________________

10. Please list any additional medical information (surgery, serious illnesses, diagnoses or hospitalizations):
    __________________________________________________________________________________________________________
    __________________________________________________________________________________________________________
**Recreational Drug History**

Tobacco Use: 
- Past 
- Present

Alcohol Use: 
- Past 
- Present

Illicit Drug Use: 
- Past 
- Present

**Current Medications**

Please list all the medications you are using, including any Rx drugs, over-the-counter medications, supplements, vitamins, pain relievers, and any medications used “as needed”.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Current dose</th>
<th>Start date</th>
<th>Date last used</th>
<th>Reason for use</th>
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Additional comments or information:

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________

________________________________________________________________________________________________________________
**Review of Systems**

Please check all areas that apply to you, remember to include dates and "ongoing or resolved". Each Heading should have at least one check. ☑

### Head
- TMJ
- Sinus Probs
- Headache
- Other
- None

### Ears
- Itching
- Hearing loss
- Earaches
- Frequent infections
- Blockage
- Other
- None

### Nose
- Polyps
- Hayfever
- Congestion
- Runny nose
- Bleeding
- Sneeze
- Loss of smell
- Itching
- Other
- None

### Throat
- Itching
- Post nasal drip
- Bad breath
- Hoarseness
- Sore
- Voice loss
- Other
- None

### Breasts
- Discharge
- Soreness
- Lumps/Cysts
- Malignancies
- Other
- None

### Heart / Vascular
- Heart attack
- Blood pressure
- Murmur
- Abnormal beat
- Vascular disease
- Angina
- Other
- None

### Lungs
- Asthma
- Bronchitis
- Pneumonia
- Emphysema
- Cystic Fibrosis
- Chest tightness
- Wheezing
- Cough
- Other
- None

### Kidney
- Kidney stones
- Cysts
- Frequent inf.
- Glomerulonephritis
- Other
- None

### Stomach / Digestion
- Ulcers
- Heartburn
- Constipation
- Diarrhea
- Loss of appetite
- Nausea/Vomiting
- Other
- None

### Eyes
- Blurry vision
- Glaucoma
- Redness
- Other
- None

### Heart / Vascular
- Loss of appetite
- Diarrhea
- Constipation
- Heartburn
- Other
- None

### Gastrointestinal
- Headache
- Sinus problems
- Earaches
- Migraines
- Seizures
- Joint replacement
- Frequent inf.
- Multiple sclerosis
- Numbness
- Other
- None

### Neurologic
- Depression
- Anxiety
- Alcohol abuse
- Alzheimer’s
- Bi-polar disorder
- Other
- None

### Endocrine
- Thyroid
- Diabetes
- Other
- None

### Musculoskeletal
- Rheumatoid arthritis
- Osteoarthritis
- Joint replacement
- Broken bones
- Osteoporosis
- Other
- None

### Genitourinary
- Uterine/cervical cancer
- Ovarian cysts
- Ulcers
- Frequent inf.
- Prostate cancer
- Prostate enlargement
- Menstrual cramps
- Other
- None

### Dermatologic
- Eczema
- Acne
- Psoriasis
- Cancer
- Tching/Dry
- Infection
- Other
- None

### Skin
- Eczema
- Acne
- Psoriasis
- Cancer
- Tching/Dry
- Infection
- Other
- None

*My signature indicates that this medical history is accurate to the best of my knowledge.*

Signature ___________________________ Date __________________

(Parent or Insured if Minor)

Doctor’s Signature ___________________________ Date __________________