Allergy & Asthma
TEXAS HEALTH
Together we can!

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Board Certified Adult & Pediatric Allergist and Immunologist

Patient Name: _____ Age: _____ Date: ____/____/____
Primary Dr: _____ Practice Type: ☐ Pediatrics ☐ Family Practice
Referred by: _____ ☐ Self-referred ☐ Other: _____

Reason for visit:

☐ nose symptoms ☐ sinus symptoms ☐ cough ☐ trouble breathing
☐ asthma/wheezing ☐ hives ☐swelling ☐ rash ☐eczema ☐ food reactions
☐ drug allergy ☐ insect sting allergy ☐ recurring infections ☐ other _____

Please indicate the patient's symptoms (check all that apply):

General

☐ fever ☐ chills ☐ fatigue

Nose

☐ stuffy nose ☐ runny nose w/ clear nasal discharge ☐ runny nose w/colored nasal discharge ☐ sneezing ☐ itchy nose
☐ frequent sniffling ☐ loss of smell ☐ loss of taste ☐ nose bleeds
☐ mouth breathing ☐ loud snoring ☐ sinus pain ☐ nasal polyps
The severity of the nasal symptoms at their worst is: ☐ mild ☐moderate ☐ severe

Eyes

☐ watery eyes ☐ itchy eyes ☐ red eyes ☐ puffy eyelids
☐ eye drainage ☐ dryness ☐ burning ☐ blurred vision

Ears

☐ itchy ears ☐ stuffiness/popping ☐ hearing loss ☐ ear infections

Throat and mouth

☐ itchy throat/palate ☐ sore throat in the morning ☐ hoarseness ☐ throat clearing /postnasal drip

Head

☐ sinus headaches ☐ migraine headaches ☐ dizziness

Chest

☐ nighttime cough ☐ daytime cough ☐ coughing up mucus ☐ wheezing
☐ short of breath ☐ pain/tightness ☐ symptoms with exercise

Stomach

☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation
☐ heartburn ☐ pain/cramping ☐ chocking with food

Skin

☐ hives ☐ itchy skin ☐ skin rash ☐ swelling

Other

☐ poor sleep ☐ body aches ☐ arthritis ☐ Other_____

Immunology History: (please check all that apply)

☐ recurrent **sinus** infections ☐ recurrent **ear** infections ☐ recurrent **throat** infections
☐ recurrent **pneumonia** ☐ recurrent **bronchitis** ☐ recurrent **skin** infections

When did **each of the symptoms** initially occur (age or date)?

_____

_____

Nose/sinus symptoms are worse (check all that apply):

☐ All Year ☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ Indoors ☐ Outdoors

What triggers nose, eye, ear, head, skin, swelling, stomach or other symptoms?

☐ colds	☐ exercise	☐ smoke	☐ dusty areas
☐ dog	☐ cat	☐ strong odors	☐ perfume
☐ weather changes	☐ dampness/rain	☐ air conditioning	☐ foods
☐ molds	☐ grass	☐ weeds	☐ trees
☐ flowers	☐ smog	☐ menstruation	☐ strong emotions
☐ cosmetics	☐ soaps	☐ fabrics	☐ paint/varnish

☐ medications: _____ ☐ other: _____

Please describe any significant reactions to <u>insect stings</u>:

_____

Please list any reactions to <u>foods</u>:

_____

Please describe any significant reactions to <u>latex</u>:

_____

<u>If you have asthma, wheezing, or shortness of breath:</u> ☐ Not applicable

Age at onset: _____ # of hospitalizations: _____ ICU admissions: _____

In the past 12 months how many:

Attacks? _____ Missed school/work days? _____

ER visits? _____

On average, how many days a week have you used albuterol within the past month: _____

Oral steroid courses (i.e. prednisone, prednisolone, Medrol, dexamethasone, decadron? _____

Do your chest symptoms awaken you at night? ☐ Yes ☐ No

Is your activity, including exercise, restricted due to chest symptoms? ☐ Yes ☐ No

When are your chest symptoms at their worst?

☐ Year round ☐ Jan ☐ Feb ☐ Mar ☐ Apr ☐ May ☐ Jun ☐ Jul ☐ Aug ☐ Sept ☐ Oct ☐ Nov ☐ Dec

Previous allergy or immunology testing? ☐ Yes ☐ No If yes, please describe: _____

_____

By Dr: _____

Year: _____

Previously/currently on allergy shots? ☐ Yes ☐ No If yes: For __years Shots helped? ☐ Y ☐ N

Previous CAT scan of the sinuses: ☐yes, when: _____ ☐ No

Previous chest XR: ☐yes, when: _____ ☐ No

Current Medications (include prescriptions, over the counter, herbals, vitamins, mineral, dietary, etc.)

MEDICATION	STRENGHT	DOSAGE	ROUTE	FREQUENCY	DATE STARTED/PRESCRIBING PROVIDER

What allergy medicines has the patient taken in the past? (please circle all that apply)

☐ antihistamines? Zyrtec (cetirizine), Xyzal, Claritin (loratadine), Clarinex, Allegra (fexofenadine)
☐ nasal steroids? Flonase (fluticasone), Nasonex (mometasone), Qnasl, Rhinocort, Nasocort, Veramyst, Omnaris
☐ nasal antihistamines? Astelin, Astepro, Patanase
☐ Singulair (montelukast)? ☐ Dymista ☐Afrin ☐" D" preparations (i.e. Claritin D)
☐ **Other:**

_____

Any medication allergies? ☐ None ☐ Allergic to:

_____

Please list current or past significant health conditions:

_____

_____

☐ Heartburn/gastric reflux ☐ Obstructive sleep apnea ☐ Heart disease/problems ☐ High blood pressure
☐ High cholesterol ☐ Diabetes ☐ Anxiety ☐ Depression

If the patient is a child under 6, please answer the following:

Were there any problems with the pregnancy or delivery?

_____

Surgical history (with age at time of procedure):

☐ Tonsillectomy & adenoidectomy ----------

☐ Ear tubes ----------

☐ Open heart surgery ----------

☐ G-tube placement ----------

☐ Tracheostomy ----------

☐ Other not included in this list _____

_____

Are immunizations up to date? ☐ Yes ☐ No

Family (immediate) History check all that applies and write relationship to patient:

☐ Allergies (Hay fever) _____ ☐ Asthma _____ ☐ Eczema _____ ☐ Food allergy _____

☐ Bee sting allergy _____ ☐ Cystic fibrosis _____ ☐ Nasal polyps _____

☐ Immune deficiency/disorder _____ ☐ Swelling episodes

☐ Other chronic illness _____

Please provide information about your child's home environment:

Housing ☐ house ☐ apartment ☐ mobile home

Flooring: ☐ carpet ☐ tile ☐ wood ☐ vinyl

Exposures: ☐ strong fumes ☐ pollution ☐ fireplace ☐ wood-burning stove

Air conditioning: ☐ central ☐ window ☐ no air conditioning

Pets: ☐ Cats (___#) inside/outside ☐ Dogs (__#) inside/outside ☐ Other Pets: _____

Smoking inside/outside the home: ☐ Yes (see below) ☐ No

☐ Self (patient) ☐ Mother ☐ Father ☐ Other(s): _____

How long have you lived in Texas? _____ **Previous location(s)**: _____

Who lives in the home with the patient? _____

Occupation/hobbies: _____

Preferred Pharmacy: _____

All pages reviewed by provider: _____ **Date:** ____/____/____