ALLERGY AND ASTHMA CARE, P.A.

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Richard J. Morris, M.D.
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Name: _____

Date of Birth: _____

Today's Date: _____

Primary physician's name: _____
Primary physician's address: _____
_____

Was consultation recommended by a provider? Y/N
Referring physician's name (if different): _____
Referring physician's address: _____
_____

Patient- Please fill out this side: **Physician Notes:** _____

(IF YOU ARE CONCERNED ABOUT HIVES OR FOOD ALLERGIES, PLEASE ALSO FILL OUT PAGE 4)

The main problems are:

YES	NO		
☐	☐	Nasal congestion	
☐	☐	Runny nose	
☐	☐	Itchy or watery eyes	
☐	☐	Sneezing	
☐	☐	Snoring	
☐	☐	Drainage down the throat	
☐	☐	Frequent yellow or green nasal drainage	
☐	☐	Number of ear infections in the past year: _____	
☐	☐	Number of sinus infections in the past year: ____	
☐	☐	Coughing	
☐	☐	Wheezing or shortness of breath	
☐	☐	Diagnosis of asthma? Age_____	
☐	☐	Number of past hospitalizations for asthma____	
☐	☐	Number of past emergency room visits for asthma___	
☐	☐	Days of school or work missed in past year____	
☐	☐	Reaction to food: _____	
☐	☐	Bee sting reactions	
☐	☐	Rashes (e.g. eczema etc)	
☐	☐	Frequent infections	
☐	☐	Number of pneumonias during lifetime: _____	
☐	☐	Headaches	
☐	☐	Vomiting, diarrhea, or abdominal pain	
☐	☐	Transfer of allergy care from Dr. _____	
☐	☐	Continuation of allergy shots started____years ago	
☐	☐	Other (explain):	

These symptoms occur:

☐ Spring ☐ Summer ☐ Fall ☐ Winter
☐ Days or weeks at a time ☐ All the time
Best time of year: _____

Symptoms are made worse by:

☐ Cats	☐ Heat
☐ Dogs	☐ Cold
☐ Exercise	☐ Perfumes/Scents
☐ Colds	☐ Dusting/Cleaning
☐ Cigarette smoke	☐ Food: _____
☐ Mowing Grass	☐ Drugs: _____
☐ Raking Leaves	☐ Other: _____

Physician Notes

All Current Medicines:

	number of mg, tabs, caps, or inhaler puffs		
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____
_____	_____	_____times per day	_____

Previous allergy or asthma medications (including OTC):

_____	☐ helped	☐ no help	_____
_____	☐ helped	☐ no help	_____
_____	☐ helped	☐ no help	_____
_____	☐ helped	☐ no help	_____
_____	☐ helped	☐ no help	_____

Past Medical History:

Birth Weight: _____Problems at Birth? YES / NO _____

Surgeries:

(Age or year)

_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____

Hospitalizations (other than surgery):

(Age or year)

_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____
_____	for	_____	_____

Drug Allergies:

_____	caused	_____	_____
_____	caused	_____	_____

Immunization Adverse Reactions:

_____	caused	_____	_____
_____	caused	_____	_____

Past Allergy History: (use space at right if needed)

YES NO

☐ ☐ Previous allergy testing (If 'yes' then answer the questions below) _____

Testing by Dr._____in _____ _____

☐ ☐ Previous allergy shots _____

Currently on allergy injections every ___weeks _____

Current Environment:

YES	NO		YES	NO	
☐	☐	Cats	☐	☐	Cigarette smoke _____
☐	☐	Dogs	☐	☐	Forced air heat _____
☐	☐	Birds	☐	☐	Wood burning stove _____
Other pets: _____			☐	☐	Air conditioning _____
☐	☐	Feather pillow	☐	☐	Damp basement _____
☐	☐	Down comforter	☐	☐	Mold growth _____
☐	☐	Bedroom Carpet	☐	☐	Whole house air cleaner _____
☐	☐	Room air cleaner	Workplace: _____		_____

Physician Notes

Family History:

	Allergies	Asthma
Mother	☐	☐
Father	☐	☐
Sister (s) #_____	☐	☐
Brother (s) #_____	☐	☐
Your children #_____	☐	☐
Grandmother (s)	☐	☐
Grandfather (s)	☐	☐
Aunt (s)	☐	☐
Uncle (s)	☐	☐
Cousin (s)	☐	☐

Other chronic family conditions such as cystic fibrosis, emphysema, recurrent hives or swelling, immune deficiency, cancer, diabetes etc:

_____

_____

_____

Social History:

Current occupation is: _____

If child, primary residence is: ☐ one home
☐ split between homes

Activities: _____

Review of Systems: (check if present)

- ☐ Problem with Growth/Weight
- ☐ Pediatric Developmental Problems
- ☐ Fevers
- ☐ Skin Problems
- ☐ Blood Count Problems (anemia, etc.)
- ☐ Eye Diseases (e.g. glaucoma, cataracts)
- ☐ Hearing Problems
- ☐ Thyroid Disorder
- ☐ Lung Disease (other than asthma)
- ☐ Heart Problems or High Blood Pressure
- ☐ Stomach Upset, Heartburn/Reflux
- ☐ Bowel Disorder
- ☐ Liver Disorder
- ☐ Prostate Problem
- ☐ Urinary or Bladder Problems
- ☐ Gynecologic Problems
- ☐ Mental Health Problems
- ☐ Hormone Problems (such as diabetes, menopause, etc.)
- ☐ Bones & Joints
- ☐ Cancer
- ☐ Autoimmune Disease (e.g. Lupus, Rheumatoid Arthritis)
- ☐ HIV Infection

Other comments:

_____

_____

_____

_____

Name of person filling out this history form (print): _____

Relationship if not the patient: _____

IF YOU ARE CONCERNED ABOUT HIVES OR FOOD ALLERGIES, PLEASE FILL OUT PAGE 4

IF YOU ARE CONCERNED ABOUT HIVES OR FOOD ALLERGIES, PLEASE ANSWER THESE QUESTIONS:

HIVES:

Physician Notes

Do you have any other symptoms at the same time?
Wheezing? Y/N
Trouble swallowing? Y/N
Sensation of throat closing? Y/N

Review of Systems
History of low or high thyroid? Y/N
History of hepatitis? Y/N
History of lupus or rheumatoid arthritis? Y/N
Do you work around latex rubber products? Y/N
Do you frequently take Aspirin, Ibuprofen or NSAID's? Y/N

FOOD ALLERGY:

What are your symptoms?
Hives? Y/N
Wheezing? Y/N
Throat swelling or trouble swallowing? Y/N
Vomiting or abdominal pain? Y/N
Eczema? Y/N
Other symptoms? Specify_____
_____

Do you know what food causes a reaction? Y/N
Specify: _____
_____

How soon after eating this food do the symptoms appear?
_____
_____

How much of the food do you eat before the reaction occurs?
_____
_____

Have you ever required an ER visit or hospitalization for a food reaction? Y/N _____
_____

Have you ever had testing for food allergies? Y/N
_____
_____