Allergy and Asthma Institute of Johns Creek

First Name: _____________________ **MI:** ____ **Last Name:** _____________________ **DOB**: _______________

Mother's Name (if patient is child): ____

Father's Name (if patient is child): ____

Reason for your visit today: ____

Symptoms: □ Itchy Nose □ Runny Nose □ Post-Nasal Drip □ Trouble Breathing □ Congestion
□ Itchy Throat □ Itchy Eyes □Watery Eyes □ Red Eyes □ Swollen Eyes
□ Hives □ Itchy Rash □ Cough □ Sneezing □ Wheezing
□ Lip Swelling □ Lip Swelling □ Difficulty Swallowing
□ Other: ____

How long have you had these symptoms? ____

How often do you experience these symptoms? ____

What triggers these symptoms? (i.e., exposure to certain animals, seasons, being outdoors, etc.) __________

____

Medications you are currently taking: (including over the counter medicines)

Medication Name	Dose (10 mg, 1 tsp, 2 puffs, etc)	Frequency (1 x day, at bedtime, as needed, etc)

When is the last time you took an antihistamine (allergy medicine)? ___________________________________

Past Allergy History:

Have you ever seen an allergy doctor? □ No □ Yes

If yes, Name: ________________________________ City: _________________________ Year: ___________

Have you ever been on allergy shots? □ No □ Yes If yes, how many years: ___________

Are you allergic to any medications? □ No □ Yes (if yes, please list along with symptoms of reaction)

____

____

Have you ever had a reaction to an insect sting, other than pain and swelling at the Sting site? □ No □ Yes

If so, please describe ____

____

Past Medical History:

☐ Asthma: Hospitalizations ____

☐ Auto Immune Disease: ___________________________ ☐ Immune Deficiency: ___________________________

☐ Pneumonia ☐ Emphysema ☐ COPD

☐ Cancer: _____________________________________ ☐ Psychiatric/Mental Health: _________________________

Other: ____

Past Surgeries (Procedure/Date):

____

____

____

____

Hospitalizations (Reason/Date):

____

____

____

____

Family Health History:	Seasonal Allergies	Food Allergy	Insect Allergy	Asthma	Eczema	Frequent Infections	Swelling/ hives	Other
Mother								
Father								
Sister								
Brother								

Smoking History:

☐ Non-Smoker

☐ Former Smoker: Start Year _____ Stop Year _____

☐ Current Smoker: ____ pack(s) per day, for ___ years

Are there smokers in the house? ☐ No ☐ Yes

Pets:

☐ Dog(s) # ________ ☐ Cat(s) # ________ ☐ Bird(s) # ________ ☐ Other ___________________________________

Home:

Do you live in the ☐ City ☐ Country ☐ Suburb

Do you live in a ☐ House ☐ Mobile Home ☐ Apartment

☐ Mostly Carpet ☐ Mostly Hardwood ☐ Stuffed animals

☐ Central Air/Heat ☐ Window AC Unit ☐ Humidifier ☐ Air Purifier

How old is the home? _____ years

Allergy covers on mattress/pillows? ☐ No ☐ Yes

Social History:

Who lives in the house? ____

Occupation or Grade Level: ________________________ Name of school or work: ___________________________

Attends daycare: ☐ No ☐ Yes

Diet:

Do you have any reactions to food ☐ No ☐ Yes If so please describe, ___________________________________

____

____

Are you on a special diet? ☐ No ☐ Yes ____