WELCH PASTEUR ALLERGY MEDICAL GROUP

Name: ______________________ Date: ______________________

Your Complaints: ____

If you have nose and asthma problems, check all the following that make your symptoms worse

Seasonal

☐ Grass ☐ Cats ☐ Trees ☐ Dogs ☐ Dust ☐ Weeds ☐ Mold-Vegetation/ Soil Rotting Wood

Non-Allergic

☐ Smoke ☐ Paint Fumes ☐ Changes in Humidity ☐ Exhaust ☐ Windy Days ☐ Hairspray ☐ Wine ☐ Changes in Temperature ☐ Gasoline ☐ Spicy Food ☐ Cleaning Product ☐ Smell of Perfume/ Cologne

Are you allergic to any Medications?

Drug Name	Reaction

Medications: Please list your current medications

Name of Medications	Dosage	How many times a day do you take it?

Past Medical History: Do you have the following?

Respiratory (Past / Current)
- ☐ ☐ Asthma
- ☐ ☐ Emphysema
- ☐ ☐ Pneumonia
- ☐ ☐ Bronchitis
- ☐ ☐ Sinusitis
- ☐ ☐ Lung Cancer
- ☐ ☐ Sleep Apnea
- ☐ ☐ TB
- ☐ ☐ Hay Fever

Skin (Past / Current)
- ☐ ☐ Hives
- ☐ ☐ Rashes
- ☐ ☐ Eczema
- ☐ ☐ Itchiness

GI (Past / Current)
- ☐ ☐ IBS
- ☐ ☐ Colitis
- ☐ ☐ Ulcers
- ☐ ☐ Reflux/Heart Burn

Psychiatry (Past / Current)
- ☐ ☐ Depression
- ☐ ☐ Insomina
- ☐ ☐ ADD
- ☐ ☐ Sexual Impotence

Miscellaneous (Past / Current)
- ☐ ☐ Migraine
- ☐ ☐ Arthritis
- ☐ ☐ Cancer
- ☐ ☐ HIV/AIDS
- ☐ ☐ Bleeding Disorder
- ☐ ☐ Anaphylaxis
- ☐ ☐ Other

Past Surgical History

☐ Tonsilectomy ☐ Sinus Surgery ☐ Adenoidectomy ☐ Other Please Specify: __________

Family History

Mother
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Sleep Apnea

Father
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Sleep Apnea

Brother
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Sleep Apnea

Sister
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Sleep Apnea

Grandparent (who?__________________)
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Sleep Apnea

Smoking History

Do you currently smoke? ☐ Yes ☐ No

Have you smoked in the past? ☐ Yes ☐ No

Any second hand smoking? ☐ Yes ☐ No

How many years do/did you smoke for? ___________

Average, how many cigarettes do you smoke a day when you are/were smoking? ________________

Drinking History

Do you drink alcohol? ☐ Yes ☐ No

How many drinks a week? ______________________

Any illicit drug use in the past? ☐ Yes ☐ No

Any illicit drug use current? ☐ Yes ☐ No

Review of System: Please check if you have the following

General

☐ Fatigue ☐ Fever ☐ Weight Gain ☐ Night Sweats

Skin

☐ Changes in Hair/Nail ☐ Dry Skin ☐ Excessive Sweating ☐ Hives ☐ Infection

☐ Pruitis/Itching ☐ Rashes ☐ Other

Head

☐ Headache

Eyes

☐ Excessive Tearing ☐ Discharge ☐ Itching ☐ Pain ☐ Dryness

Ears

☐ Itching ☐ Earache ☐ Hearing Loss ☐ Infection ☐ Tinnitus

☐ Vertigo ☐ Popping of ear

Nose & Sinus

☐ Facial Pressure ☐ Frequent Colds ☐ Loss of sense of smell ☐ Nose Congestion ☐ Sinus Headache

Mouth & Throat

☐ Dry Mouth ☐ Sore Throat ☐ Hoarseness ☐ Grinding of Teeth ☐ Halitosis/Bad Breath

☐ Wears mouth Guard

Neck

☐ Swelling ☐ Swollen Gland ☐ Thyroid Problems

Respiratory

☐ Chest pain ☐ Cough ☐ TB ☐ Wheezing ☐ Recent CXR

☐ Nighttime choking/gasping ☐ Shortness of breath on exercise

Cardiac

☐ Murmur ☐ High Blood Pressure ☐ Irregular heart beat

GI

☐ Pain ☐ Belching ☐ Bloating ☐ Diarrhea ☐ Nausea

☐ Gas/ Flatulence ☐ Blood in stool ☐ Black color stool ☐ Rectal Bleeding ☐ Trouble swallowing

☐ Vomiting ☐ Trouble swallowing ☐ Dysphagia (food getting stuck when Swallowing)

Sleep

☐ Irritability ☐ Snoring ☐ Awakening at night ☐ Poor concentration

☐ Toss & turn in bed ☐ Non fresh sleep ☐ Short term memory loss ☐ Early afternoon fatigue

Neurological

☐ Dizziness

Anything you would like to tell us?

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