WELCH PASTEUR ALLERGY MEDICAL GROUP
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211 QUARRY ROAD SUITE 106, MAIL CODE 5996
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PH: 650-322-3847 FAX:650-322-3249

Name:_____ **DOB:** _____ **Date:**_____

Your Complaints:_____

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

Seasonal
- ☐ Grass
- ☐ Weeds
- ☐ Trees

Perennial
- ☐ Dust
- ☐ Dog
- ☐ Cat
- ☐ Cockroaches
- ☐ Mold-Vegetation/ Soil Rotting Wood

Non-Allergic
- ☐ Smoke
- ☐ Paint Fumes
- ☐ Spicy Food
- ☐ Exhaust
- ☐ Windy Days
- ☐ Cleaning Product
- ☐ Gasoline Fumes
- ☐ Wine
- ☐ Changes in Temperature
- ☐ Smell of Perfume Fragrances
- ☐ Changes in Humidity
- ☐ Hairspray

Are you allergic to any medications? ☐ **NOT THAT I KNOW OF**

Drug Name	Reaction

Medications: Please list your current medications **IF NO MEDICATION, MARK HERE:** ☐

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

Past Medical History: Do you have the following? **IF NONE APPLY PLEASE MARK HERE:** ☐

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
☐	☐	Insomnia
☐	☐	ADD
☐	☐	Sexual Impotence

Miscellaneous

Past	Current	
☐	☐	Migraine
☐	☐	Arthritis
☐	☐	Cancer
☐	☐	HIV/AIDS
☐	☐	Bleeding Disorder
☐	☐	Anaphylaxis
☐	☐	Other: Specify

_____

Past Surgical History

☐ Adenoidectomy ☐ Tonsillectomy ☐ Sinus Surgery ☐ Other, Please Specify:_____

Family History Only Child: ☐

Father ☐ Not Sure	Mother ☐ Not Sure	Brother ☐ Not Sure	Sister ☐ Not Sure
☐ Allergies	☐ Allergies	☐ Allergies	☐ Allergies
☐ Asthma	☐ Asthma	☐ Asthma	☐ Asthma
☐ Eczema	☐ Eczema	☐ Eczema	☐ Eczema
☐ Sleep Apnea	☐ Sleep Apnea	☐ Sleep Apnea	☐ Sleep Apnea

Grandmother (Paternal or Maternal) ☐ Not Sure
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Sleep Apnea

Grandfather (Paternal or Maternal) ☐ Not Sure
- ☐ Allergies
- ☐ Asthma
- ☐ Eczema
- ☐ Sleep Apnea

Smoking History

Do you currently smoke?
If yes, how many years have you smoked for? _____
How many cigarettes a day do you smoke?_____

Have you smoked in the past? ☐ Yes ☐ No
If yes, how many years did you smoke? _____
How many years ago did you quit? _____
How many cigarettes a day did you smoke?_____

Any Illicit drug use in the past? ☐ Yes ☐ No
Any Illicit drug use currently? ☐ Yes ☐ No

Do you use a vape pen? ☐ Yes ☐ No If yes, ☐ THC ☐ Nicotine ☐ CBD
☐ OTHER:_____

Drinking History

Do you drink alcohol? ☐ Yes ☐ No
How many drinks a week? _____

Home Questionnaire

1. Number of years in house: _____
2. Flooring in bedroom: Hardwood Carpet
3. Windows: Single Pane Double Pane
4. Mattress Age: _____ Months _____ Years
5. Pillow Age: _____ Months _____ Years **Type:** Tempurpedic Feather Foam
6. Comforter Age: _____ Months _____ Years **Type:** Feather Non-Feather
7. Do you have Dust Mite Covers? Yes No **If Yes:** Pillows Mattress Comforter
8. Pets? Dog Cat Other:_____ How Many?_____ How Long?_____
9. Heating: Forced Radiant
10. Vacuum Frequency:_____
11. Vacuum Type: HEPA Non-HEPA
12. Books in Bedroom: Yes No
13. Upholstered Furniture: Yes No
14. Do you live in the: Suburbs City

IF THERE IS ANYTHING ELSE YOU WOULD LIKE TO MENTION PLEASE WRITE IT DOWN BELOW:

_____
_____
_____
_____
_____

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NAME:_____ **DOB:**_____

Review of Symptoms: Please check if any currently apply. If none, Please mark here ☐

General:
☐Fatigue ☐Fever ☐Weight Gain ☐Night Sweats ☐Other: _____

Skin:
☐Changes in hair/nails ☐Dry Skin ☐Excessive Sweating ☐Hives ☐Infection ☐Pruitis/Itching ☐Rashes
☐Other: _____

Head:
☐Headache

Eyes:
☐Excessive Tearing ☐Discharge ☐Itching ☐Pain ☐Dryness ☐Other:_____

Ears:
☐Itching ☐Earache ☐Hearing Loss ☐Infection ☐Popping of ear ☐Tinnitus ☐Vertigo ☐Other: _____

Nose & Sinus:
☐Facial Pressure ☐Frequent Colds ☐Loss of Sense of Smell ☐Nose Congestion ☐Sinus Headache ☐Other: _____

Mouth & Throat:
☐Dry Mouth ☐Sore Throat ☐Hoarseness ☐Grinding of Teeth ☐Halitosis/Bad Breath
☐Wears Mouth Guard ☐Other: _____

Neck:
☐Swelling ☐Swollen Glands ☐Thyroid Problems

Respiratory:
☐Chest Pain ☐Cough ☐TB ☐Wheezing ☐Recent CXR ☐Nighttime choking/gasping
☐Shortness of breath on exercise ☐Other: _____

Cardiac:
☐Murmur ☐High Blood Pressure ☐Irregular Heart Beat ☐Other: _____

GI:
☐Abdominal Pain ☐Belching ☐Bloating ☐Diarrhea ☐Dysphagia(Food getting stuck while swallowing) ☐ Flatulence/Gas
☐Heartburn ☐Hematologic/ Blood in Stool ☐Hemorrhoids ☐Indigestion ☐Melena/ Black Stool ☐Nausea
☐Rectal Bleeding ☐Trouble Swallowing ☐Vomiting ☐Other: _____

Sleep:
☐Awakening at night ☐Early Afternoon Fatigue ☐Irritability ☐Non Refresh Sleep
☐Poor Concentration ☐Short Term Memory Loss ☐Snoring ☐Toss and Turn at Night

Neurological:
☐Dizziness ☐Memory Loss ☐Seizures ☐Tremors ☐Vertigo