Comprehensive Allergy & Asthma
Allergy/Immunology Evaluation

Patient Name: ______________________________
Date of Birth: ______________________________
Primary Care Physician: ______________________________
Referring Physician: ______________________________
Pharmacy name and number: ______________________________

What problem or symptoms are you or your child currently experiencing?

____

When did the symptoms begin? ______________________________
Are these problems getting worse? ______________________________
Have you missed school or work? ______________________________
If yes, how much time was lost? ______________________________

Do you have or experienced any of these symptoms in the past 4 weeks?

___ Cough	___ Sneezing	___ Nasal polyps	___ Rashes
___ Wheezing ___ Breathless at times	___ Runny Nose	___ Poor sense of smell	___ Hives/Swelling
___ Sputum/Phlegm	___ Nose Bleeds	___ Sinus infection	___ Swollen Glands
___Fatigue When?	___ Congestion Nose/sinuses?	___ Blocked ears	___ Itch __flushing
__ Shortness of Breath	___Itchy nose	___ Headaches	___ Diarrhea
___ Tire easily/ Fatigue	___ Post Nasal Drip	___ Skin infections	___ Constipation
___ Hoarseness	___ Tearing/ Watery eyes	___ Joint pain	___ Bad Breath
___ Snoring	Sleep problems:	Mood changes:	Heartburn/GERD

Check any of the following which trigger or cause your symptoms?

___ Grass	___ Horses	___ Humidity	___ Leaves/Hay
___ Mold/Mildew	___ Alcohol ingestion	___ Weather Changes	___ Foods
___ Basements	___ Cleaning Agents	___ Latex	___ Dust
___ Perfumes	___ Strong Odors	___ Cosmetics	___ Newsprint
___ Cats	___ Tobacco Smoke	___ Medications	___
___ Dogs	___ Cold Air	___ Strong emotions	Other:

Are your symptoms:

___ Year Round	___ Spring	___ Summer	___ Fall	___ Winter

Are your symptoms worse:

___ On vacation	___ At work	___ At school	__ With hobbies

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Height: ______

Weight: ______

BP: ___/______

Pulse: _______

Pox: _______

Pre:
FEV1________( )
FVC________( )
PEF________( )
EF25-75 ( )

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Patient Name: ____

Post	
FEV1________	( )
FVC________	( )
PEF________	( )
EF25-75	( )

What helps you with your symptoms?

___ Anti-histamines:____

___ Nose Sprays: ____

___ Antibiotics: ____

___ Supplements____

___ Other: ____

Living Environment:

Type of home: ___ Home ___ Apartment ___Condo ___Dorm

Is there a basement? ___ Yes ___ No

If so, is there any mold or damp smell? _________

Any problems with: ___ mice ___ roaches

Tobacco use/exposure: ___ Nonsmoker ___ Exposure to 2nd hand smoke

Former smoker: How long did you smoke?____ years When did you quit? _______

Any indoor plants? _____________ Any pets? __cat(s) ____dog(s) ___ bird(s)

Medication/Supplements/Vitamins: Please list all medications and supplements

Name/Dosage	Frequency	For what condition(s)?

Food Allergies/Sensitivites:

(Describe reaction: Swelling? Rash? Vomiting? Cough? Anaphylaxis?)

___ Eggs		___ Melon	
___ Wheat		___ Bananas	
___ Milk		___ Walnuts	
___ Cheese		___ Peanuts	
___ Shellfish		___ Soy	
___ Tomatoes		___ Legumes	
___ Apples		___Spices	
___ Fish		___	

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Patient Name: ____

Drug Allergies/Sensitivities – Please list medications and describe the reaction:

Medication	Reaction

Your Health History: Please check the conditions that you have had in the past?

___ Hypertension	___ Cancer:	___ Kidney Disease	___ Diarrhea
___ Heart Disease	___ Diabetes	___ Acne	___ Eczema
___ Arthritis	___ Thyroid Disease	___ Heartburn	___ Hives
___ Skin Infections	___ Liver Disease	___ Pneumonia	___ Sinusitis
___ Headaches	___ Allergies	___ Asthma	___ Eye Disease
___ Ear Infections	___ Bronchitis	___ Ear Infections	___ HIV/AIDS
___ IBS	___ Crohn's Ds.	___ Ulcerative Colitis	__Psoriasis

Other____

Any Surgeries that you have had in the past:

___ Sinus	__ Tonsils	__ Adenoids	__ Orthopedic	__Other_______________

Family History: Please check chronic illness or disease in your family

___ High blood pressure	___ Cancer	___ Kidney Disease	___ Chronic Diarrhea
___ Heart Disease	___ Diabetes	___ Arthritis	___ Eczema
___ Arthritis	___ Thyroid Disease	___ Heartburn	___ Hives
___ Irritable Bowel	___ Liver Disease	___ Pneumonia	___ Sinusitis
___ Headaches	___ Allergies	___ Asthma	___ Eye Disease
___ Respiratory Infection	___ Bronchitis	___ Ear Infections	___ Immune Deficiency
___ Receive blood products/transfusions	__ Anxiety	___Depression	__ Other

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Patient Name:	**Patient Signature:**	**Date:**

Patient Name: ____

Assessment/Plan:

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Patient Counseling:

The total encounter time with patient was _____ minutes, of which greater than _____ percent were spent counselling in face-to-face contact obtaining history, review test results, medication use, potential side effects, diagnoses, prognoses as well as treatment plan.

Physician Name:	**Physician Signature:**	**Date:**