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ADULT PATIENT REGISTRATION

Name: _____ Age: _____ Date of Birth: _____

Date of Visit: _____ Sex: Male/ Female

Phone: Home: _____ Cell: _____

Email: _____ Work: _____

Whom may we thank for referring you? _____

Primary Care Doctor: Dr. _____ **Other MD's treating you:** _____

Females only: Are you pregnant or nursing a child? Yes No

Any known **Drug (Medication) Allergies?**

If yes, list: _____

What type of reaction occurs? _____

Any known **Food Allergies?**

If yes, list and briefly describe reaction: _____

List medicines you use for the relief of allergy symptoms (Including nose drops, sprays, eye drops):

_____

_____

_____

List other medications you take for any reason (include over the counter drugs, herbal remedies, alternative remedies, Vitamins, Mineral supplements, Aspirin/ NSAIDS etc): Let the doctor know if you take any beta-blocker medications (including Sectral, Tenormin, Ziac, Coreg, Normodyne, Lopressor, Toprol, Corgard, Inderal, etc., or eye drops _____

_____

_____

Please answer ALL questions:

What is your primary reason or chief complaint for seeing allergy doctor today? (Describe in detail).

Allergies Sinuses Asthma Hives Food allergies Itching Rash
Allergic Reaction Eczema Insect Stings Drug Allergies Latex Allergy **Others**

_____

_____

_____

_____

CIRCLE MAJOR SYMPTOMS (Problems) – *those that prompted your visit here:*

NOSE:	Runny nose-Watery	Stuffy nose/Blocked nose			Itching/Rubbing the nose	
	Sneezing	Nosebleeds	Snoring or Mouth breathing		Loss of smell	
EYES:	Dark Circles	Itching	Burning	Redness	Tearing	Swelling
EARS:	Itching	Popping/ Fullness of ears			Blocking	Infections
	Hearing Loss	Dizziness	Drainage from outer ear			
THROAT:	Itching	Drainage/Post nasal drip	Constant clearing of the throat			Sore throat
	Mucus in the morning	Voice loss	Hoarseness			Sinus infections

CHEST: Cough Wheezing Bronchitis Shortness of breath Chest tightness
Cough or Shortness of breath on exercise/ sports Chest Infections
Inability to get a good breath or let all air out of lungs

HEADACHE: Over eyes Over cheeks/mid face Back of neck
Sinus headache Migraine Tension
Associated triggers and symptoms:

SKIN: Hives/welts Dryness Eczema Itching Other

INSECT STING REACTIONS or Allergic Reactions: Hives Swelling Shortness of breath
Itching Dizziness Fainting

STOMACH: Nausea Vomiting Cramps Bloating Indigestion
Diarrhea GE Reflux Suspect Responsible foods:

OTHERS:

How many years have you suffered from the chief complaints of?

Head or Nose symptoms _____ Chest symptoms _____
Skin symptoms _____ Insect Sting reactions _____
Others _____

Please indicate pattern of symptoms:

	Head/Nose	Chest
Year round, no seasonal change	_____	_____
Year round, worse seasonally	_____	_____
Seasonally only	_____	_____

If seasonal, list worst months; _____

Where were you living at the onset of the above problems? _____

Where else have you lived since then? _____

Circle any of the following that causes or makes your symptoms worse: (TRIGGERS)

Allergens	Irritants	Ingestants	Weather
House dust	Perfumes/Cosmetics	Alcoholic Beverages	Weather change
Fresh cut grass	Soaps/Detergents	Drugs	Cold fronts
(Lawn mowing)	Insecticide	Foods, hot spicy	Heat/Hot weather
Dead grass	Cleaning agents	Other foods/Fruits	Windy days
Old leaves	Strong odors	Others :(List)_____	Damp/Rain
Hay	Paint	_____	Muggy weather
Cats	Hair spray	_____	
Dogs	Air conditioners	_____	
Feathers	Exhaust fumes		

Misc: Exertion Cold symptoms/URI Cigarette smoke/Tobacco
Excitement Stress/Worry Laughing
Staying lakeside/barns/summer homes/dry attic Emotional upset/Depression

How soon after exposure to a trigger, do you start with allergy symptoms? _____

In a scale of 0 to 10 scale (0 is the least & 10 being highest), could you rate the degree of difficulty or impairment experienced from allergic symptoms _____

Under what circumstances are you free of symptoms (**what relieves your allergies**)? _____

What treatment have you tried or been given for this illness? _____

Antihistamines/ Decongestants/ Nose sprays/ Eye drops/Allergy shots
What helped most? _____

Have you ever had any ALLERGY SHOTS/TESTING in the past? (When, Where, Name of Doctor, How long, tests result, medications put, did the shots help you etc.)? Also, describe medications tried and whether they helped? or not?

_____

_____

Circle the time you are worst: Early morning Afternoon Evening Nighttime

Circle where you are worst: Home Outdoors At work Vacation
Staying nearby Elsewhere

Which type of weather makes your symptoms worse? Windy Cold Hot Wet Dry

Any variations of symptoms: month to month weekends or weekdays day or night indoors or outdoors
school or work staying elsewhere/ Nearby Geographical change
Effect of specific environment Travel/ Vacation

What kind of work do you do? _____ Are there any special dusts or fumes where you work? _____

Are your symptoms worse at Workplace/ School? _____

Have your symptoms been so severe as to cause you to miss work or school? _____
If yes, how many days? _____

CHILDHOOD HISTORY

Where were you born? _____
Any allergies/ asthma/ any medical problems as a child? _____
Where all you have lived? _____

PAST MEDICAL HISTORY:

1. **Do you have any medical problems? / Have you ever had any of the following (Check all that apply):**

Asthma	Recurrent infections	Cancer
Hay fever	Antibody deficiency/ immunodeficiency	Diabetes
Sinus trouble	AIDS	Glaucoma
Hives	Thrush/ Fungal infections	Cataracts
Nasal polyps	Congestive heart failure	Depression
Eczema	High Blood Pressure	Anxiety disorder
Shortness of breath	Heart attack	Lupus
COPD/Emphysema	High cholesterol	

Others_____

2. Were you ever hospitalized? If yes, provide cause of hospitalization, where & when?

_____

_____

Any ER visits? _____

Have you under gone any surgeries? _____
Did you have Tonsils taken out? _____
Others? _____

Have you ever had a chest x-ray? Yes/No If yes, when_____ where_____

Have you ever had a Sinus x-ray/ CT scan: Yes/No If yes, when_____ where_____

IMMUNIZATIONS HISTORY:

(Up to date/ Otherwise)

Flu shot/ Influenza Vaccine: _____

Pnemococcal Vaccine:

FAMILY HISTORY:
(Check all that apply & provide details)

Allergy history: Parents/ Sibs/ Children
Hay fever/ Allergies/Sinus_____
Asthma _____
Has any one in you family took allergy shots_____
Antibody deficiency/Immunodeficiency_____
Glaucoma_____
Heart attack_____
High blood pressure _____
Diabetes _____
Cancer _____
Others _____

PERSONAL HISTORY:

Marital status: _____ Education status: _____
Current occupation: _____ Past occupation: _____
Occupational exposure/ geographical exposures: _____
Hobbies/Recreation: _____
Do you have any hobbies that expose you to allergens or irritants? _____
If yes, briefly, explain_____

Do you smoke? Yes/No If yes, how many packs per day? _____ How long? _____
Have you ever smoked? Yes/No If yes, how many packs per day? _____ How long? _____
Does anyone you live with smoke? Yes/No If yes, who _____
Are exposed to smoke at work or school Yes/No
Drugs or Alcohol use_____

ENVIRONMENTAL HISTORY:

Do you live in: City Country/ Rural
Home Apartment Trailer home Mobile home
Number of bedrooms: _____ How old? _____ Style: _____
How many adults? _____ How many children? _____ Length of occupancy: _____
Heat: Central Space Air conditioner: Central Window unit
Humidifier: Central Separate Any water leaks/ moldy growths/ seepage/ flooding? _____
Waterbed Bedroom: Box spring & mattress Covers/Sheets: Cotton/ otherwise _____
Pillows: Feather / Non-feather Comforter /Blankets/Quilts: Feather / Non-feather
How old are pillows, mattress, blankets, and furniture_____
Furniture: Old/ Otherwise_____ Shelves: Old/ Otherwise_____
Flooring: Living room: _____ Bedroom: _____ Any rugs? _____
If carpeted, type and matting: _____
Pets: Cats/Dogs/ Others: _____ Are your pets kept: Inside/ outside
Does your pets sleep on the bed: Yes No
Any Cockroaches at home? _____ Any water bugs? _____
Does anybody smoke? Other family members_____
If yes, do they smoke in the house or outside? _____
Does smoke bother you or worsen symptoms_____
Are you following any environmental control measures already? _____
Disease's impact on daily functions and hobbies: _____
Are your symptoms worse anywhere in your home? _____ ***If yes, specify location***_____

ARE THERE ANY MEDICAL PROBLEMS OTHER THAN ALLERGY? (REVIEW OF THE SYSTEMS :)

EYES: _____
EAR, NOSE & THROAT: _____

PULMONARY :(Lungs) _____
ALLERGY/IMMUNOLOGICAL:_____
SKIN:_____

CONSTITUTIONAL SYMPTOMS: (Fever, weight loss etc)_____
CNS: (Brain and Nerves) _____
CARDIAC: (Heart, Elevated blood pressure, High cholesterol etc)_____
GI: (Stomach, esophagus, intestines, gall bladder etc)_____
GU: (Urinary etc)_____
HEM/ONC/LYMPHATICS: (Cancer etc)_____
INFECTIOUS: (Infections etc) _____
MULCULOSKELETAL/RHEUMATOLOGIC: (Bones & Joints) _____
SKIN: _____
PSYCHIATRIC: _____
ENDOCRINE: (Thyroid, Diabetes etc) _____

ANYTHING ELSE THAT HAS NOT BEEN DISCUSSED? (Do you have any other concerns?)