Ettienne's Premier Pediatric Care, LLC.

Allergy and Asthma Medical History

Date of Visit ____________________ **Referring MD** ____

Name ____ **DOB** ___________________________

Reason for visit: ____

Drug Allergies: ____

Pharmacy: ____ **Location:** ______________________________

Phone: ____

ALLERGY HISTORY	YES	NO
Do you have breathing problems?		
Do you have asthma?		
Do you have a wheeze?		
Do you have a cough?		
Did you ever smoke?		
Do you have sinus infections?		
Do you have nasal congestion?		
Do you have nasal drainage?		
Do you sneeze frequently?		
Do you have itchy eyes?		
Do you have itchy throat?		
Do you have itchy skin?		
Do you have any swelling?		
Do you react to drugs?		
Do you react to bee stings?		
Have you had allergy tests?		
Have you had allergy shots?		
Do you get frequent infections?		
Do you have rashes?		

Circle Your Rash: Eczema, Hives, Blisters, Other ____

When did the problem start? ____

No. of cigarettes per day/ # of years? ____

Do you react to foods? If yes, please list: ____

____

Do you have any hay fever? If yes, list months: ____

____

SOCIAL & FAMILY HISTORY	YES	NO
Parent (s) with asthma?		
Parent (s) with allergy?		
Other family with allergy/asthma?		
Family with recurrent infections?		
Family with eczema/hives?		
Family with autoimmune disease?		

ROS	CIRCLE ANY PRESENT SYMPTOMS
General	Weight Loss, Fevers, Fatigue, Sweats
Eye	Red, Dry, Blurry, Itchy, Watery, Pain
Nose	Itch, Congested, Drainage, Bloody, No Smell
Ear	Ringing, Pain, Plugged, Hearing Loss, Itch
Throat	Pain, Difficulty Swallowing, Hoarse, Itch
Heart	Chest Pains, Faint, Palpitations
Lungs	Shortness of Breath, Cough, Wheeze, Phlegm
GI	Abdominal Pain, Nausea, Vomiting, Constipation, Diarrhea, Heartburn
Joint	Stiffness, Pain, Swollen, Warm
Neuro	Numbness, Tingling, Headache, Weak
Endo	Heat/Cold Tolerance, Excess Thirst
Psych	Depression, Anxiety, Suicidal Thoughts
Skin	Itchy, Burning, Redness, Scaly, Dry

Prescription and Over the Counter Current Medications:	Refills Needed (please circle):
	YES NO
	YES NO
	YES NO
	YES NO
	YES NO

Past Medical & Surgeries	YES	NO
Do you have heart disease?		
Do you have diabetes?		
Do you have emphysema?		
Do you have high blood pressure?		
Do you have thyroid disease?		
Do you have inflammatory bowel disease?		
Have you had sinus surgery?		

Immunizations up to date? ***YES NO***

List other medical problems/surgeries:

____

____

Circle: Rheumatoid Arthritis, Thyroid, MS, Crohns, Lupus

Home environment: Smokers in Home? YES NO

Dogs at Home? How many? ______________________ Bedding? ___________________

Other furry pets? __________________________ Heat Source? ____________________

Occupation: ____

School or work exposure: ____

Hobbies: ____

Patient/Parent Signature____

MD Signature____, MD

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