Allergy & Asthma Care of New York

Name:_____ Date:_____

Referring physician/Address/Phone Number:_____

_____

Main reason for appointment today: _____

_____

Do you have:	Yes	No
Nasal congestion:	_____	_____
Sneezing:	_____	_____
Runny Nose:	_____	_____
Drainage at the back of your throat:	_____	_____
Frequent Yellow or Green Drainage:	_____	_____
Frequent Sinus Infections:	_____	_____
Itchy Eyes:	_____	_____
Watery Eyes:	_____	_____
Shortness of Breath:	_____	_____
Wheezing:	_____	_____
Coughing:	_____	_____
Diagnosis of asthma:	_____	_____
Past hospitalization for asthma:	_____	_____
Possible reactions to foods:	_____	_____
Possible reactions to medications	_____	_____
Rashes:	_____	_____
Eczema:	_____	_____
Bee/Wasp sting reactions:	_____	_____
Frequent Bronchitis/Pneumonia:	_____	_____
Reactions to Latex	_____	_____

Any other symptoms of any kind?

_____

_____

Symptoms occur most often :

_____Spring _____Summer _____Fall _____Winter _____Year round

Symptoms worse with:

____Cold Air	____Cigarette Smoke	____Chemicals	_____Aerosol sprays
____Cosmetics	____Plants (Poison Ivy)	____Dusting/Cleaning	_____Colds/Flu
____Pets	____Fresh Cut Grass	____Raking Leaves	_____Weather changes
____Exercise	____Sunscreen		

Revised on 4/30/15

Name:_____ Date:_____

Are you currently pregnant? _____No _____Yes _____Not applicable

Do you have any other medical conditions? (high blood pressure, diabetes, etc)_____

_____

Current Medications: **_____None** **____Yes**

Name	Dose	How often taking
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies to any medications: **____ No** **_____Yes**

Name of medication	Reaction you had to the medication
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Prior surgeries: ____None ___Yes

When was surgery	Type of surgery
_____	_____
_____	_____
_____	_____

Prior hospitalizations: ____None _____Yes

When hospitalized	Reason for Hospitalization
_____	_____
_____	_____
_____	_____

Family History of Medical Conditions (Asthma, Allergies, Etc) **_____ None** **_____Yes**

Relative	Conditions they have
_____	_____
_____	_____
_____	_____

Name:_____ Date:_____

Social History/Environmental History

Home Type: _____Apt
_____Condo
_____House
_____Private

Pets: _____None
_____Cats _____ How many
_____Dogs _____ How many
_____Other _____What type of pet

Carpet or Rugs in the home: _____None
_____Yes _____Bedroom _____Living Room _____Other

Mold in Home: _____None
_____Yes ____Bathroom _____Bedroom ____Other

Feather Pillow/Down Comforter: ____None
____Yes _____Down Comforter _____Feather Pillow

Special Allergy covers on bed: ____None
____Yes ___On Mattress ____On Pillows

Do you smoke? ____No
____Yes _____How much _____How long have you been smoking
____Quit _____How much _____How long _____ Stopped when
Drink alcohol? ____No ____Yes _____ Drinks per week

Use any recreational drugs: ____No ____Yes

Heating and AC type: _____Window
_____Radiator
_____Central
_____Wall unit
_____ Other

Cockroaches in the home: ____None ____Yes

Occupation: _____

Do you exercise? ____No ____Yes
Difficulty exercising? _____No _____Yes
If yes, what symptoms do you have_____

Your Height _____ Your Weight _____

Signature:_____ Date:_____

Revised on 4/30/15