BERGEN

GASTROENTEROLOGY • MEDICAL ASSOCIATES

committed to the highest level of patient care

ALLERGY & MEDICAL HISTORY

Please answer ALL the following questions as completely and accurately as possible. The information you give is very important in learning more about your allergy and how to control it. Circle or check items that apply to you and explain as needed. This way we will know you reviewed each entry.

First Name _____ Last Name _____ Birth Date _____ Appointment Date _____

Occupation _____ Days missed work or school/year _____

Hobbies _____ Latex Exposure _____ Allergy Exposure _____

List household members (Name, Age, Relationship) _____

Do any attend daycare? ◯ Yes ◯ No _____

When and where did your allergy symptoms start? Year _____ State _____ How long have you lived in this state? _____

MEDICAL PROBLEMS (breifly describe reason for allergy visit)

Current Medications: List all medications (Prescription and Over the Counter) you take routinely and on an as needed basis. Include any of the following: Aspirin, Advil, Tylenol, antacids, laxatives, vitamins & herbal products, sleeping pills, nose drops (OTC or eye drops to reduce eye pressure) and all pills to control high blood pressure, cardiac symptoms or migrane headaches. ***If you need more room, please continue on the back.***

Medication	Dosage & Directions	Date started	For what problem?	By who?	Dr. Notes

Past Medications used for Allergy and Asthma (include oral and topical corticosteroids, antihistamines, nose sprays and inhalers)

Medications	Dosage & Directions	How well did it work	Any Side Effects

Drug Allergy or Intolerance

Medication	Date of Reaction	Describe symptoms	Reused?	List Antibiotics that you tolerate

Insect Allergy (Bee, fine ant, hornet, yellow jacket, wasp etc.)

Insect if known	Date of reaction	Describe symptoms	Describe treatment

Hospitalizations for Allergies or Asthma?

Reason	Date	Treatment received	Hospital (Name & Address)

Emergency Room visits in the past 2 years for Allergies or Asthma?

Reason	Date	Treatment received	Hospital (Name & Address)

Hospitalizations during the past 5 years for a condition other than allergies or asthma and any major surgeries?

Reason	Date	Treatment received	Hospital (Name & Address)

Primary Doctor		**Address**		**Phone**	
				Fax	
Specialist (type)		**Address**		**Phone**	
				Fax	
Previous Allergist		**Address**		**Phone**	
				Fax	
Skin test done?	○Yes ○No	List positive results			
RAST blood testing?	○Yes ○No	List positive results			
Did you receive allergy shots?	○Yes ○No	Treatment dates			
Ear, Nose & Throat Doctor		**Address**		**Phone**	
				Fax	
Ear, Nose or Throat surgery?	○Yes ○No	List procedures and dates			

Procedures

Have you had in the past 12 months:		**If so, when & where was it done?**	**Results**
Physical	○Yes ○No		
Blood Work	○Yes ○No		
Have you ever had the following?			
Pulmonary Function	○Yes ○No		
Sinus C T	○Yes ○No		
Chest X-ray	○Yes ○No		
HIV test	○Yes ○No		
TB test	○Yes ○No		
Hepatitis	○Yes ○No		
Other			

Vaccine Record

	Date		**Date**	**Other Vaccine**	**Date**
Influenza		Hepatitis A			
Tetanus		Hepatitis B			
Pnuemococcal					

Have you ever had an adverse reaction to an immunization?

○ Yes ○No Describe:_____

Personal History

Smoking exposure: **Work** ○ Yes ○ No **Home** ○ Yes ○ No

Do you presently smoke? ○ Yes ○ No How long? _____

Have you ever smoked? ○ Yes ○ No Year quit: _____

What do/did you smoke? ○ Cigarettes ○ Cigars ○ Pipe Average # packs/day: _____

If you still smoke, do you think you could stop? ○ Yes ○ No

List methods you have used to stop: _____

Do you drink alcohol? ○ Yes ○ No Average #/week: _____

Are your allergy symptoms made worse by alcohol? ○ Yes ○ No

If so, explain: _____

Factors Affecting Allergy or Asthma Symptoms

Mark appropriate box if you have noticed any of the following having an effect on your allergy symptoms. Indicate areas of affect.	**Affects Skin**	**Affects Nose**	**Affects Chest**	**None**
Mowing lawn, walking or playing on grass	☐	☐	☐	☐
Other outdoor activities	☐	☐	☐	☐
High winds or riding in auto with open windows	☐	☐	☐	☐
Sweeping, dusting or using a vacuum cleaner	☐	☐	☐	☐
Moldy or mildewed areas or articles	☐	☐	☐	☐
Contact or nearness to animals Specify _____	☐	☐	☐	☐
Household cleaning agents (laundry soaps, detergents etc.). Specify _____	☐	☐	☐	☐
Strong odors Specify _____	☐	☐	☐	☐
Air conditioning at home or places you visit	☐	☐	☐	☐
Following rainfall	☐	☐	☐	☐
Trips away from home Specify area and time of year _____	☐	☐	☐	☐
Smoke or smoke exposure	☐	☐	☐	☐
Use of hair spray, tint cosmetics, perfumes, deoderants, after shave lotions, etc. Specify _____	☐	☐	☐	☐
Emotional upsets	☐	☐	☐	☐
Heavy physical exertion	☐	☐	☐	☐
Anything else you have noticed (seasonal) Specify _____	☐	☐	☐	☐

Symptoms

Please indicate if you have had any of these symptoms.	**# of days past year with symptoms**	**# of days past week with symptoms**	**Severe**	**Moderate**	**Mild**	**None**
Sneezing	☐	☐	☐	☐	☐	☐
Nasal Congestion	☐	☐	☐	☐	☐	☐
Runny Nose	☐	☐	☐	☐	☐	☐
Post Nasal Drip	☐	☐	☐	☐	☐	☐
Itchy Nose	☐	☐	☐	☐	☐	☐
Eye Symptoms	☐	☐	☐	☐	☐	☐
Ear Problems	☐	☐	☐	☐	☐	☐
Headaches	☐	☐	☐	☐	☐	☐
Migrane	☐	☐	☐	☐	☐	☐
Coughing	☐	☐	☐	☐	☐	☐
Wheezing	☐	☐	☐	☐	☐	☐
Cough or Wheeze with exercise	☐	☐	☐	☐	☐	☐
Short of breath	☐	☐	☐	☐	☐	☐
Recurrent Infections	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐
Swelling	☐	☐	☐	☐	☐	☐

Continued:

Symptoms

Please indicate if you have had any of these symptoms.	**# of days past year with symptoms**	**# of days past week with symptoms**	**Severe**	**Moderate**	**Mild**	**None**
Eczema	☐	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐	☐

Home Environment

Type of home _____
Age of home _____
Any obvious mold growth or roof leaks?
_____
Describe neighborhood (major plants, near horses, cows, wooded)
_____

Air conditioning? ◯Central ◯Room Units
Routine Service? ◯Yes ◯No
Usage: ◯All the time ◯Most of the time ◯Summer only
◯Rarely ◯Never
What type of filters do you have?
◯Disposable ◯Permanent ◯Electrostatic
How often do you clean or change your filter?_____
Do you have an air cleaner? ◯Yes ◯No
Location _____
What type of pillow do you have?
◯Feather ◯Foam ◯Dacron ◯Other _____
What type of mattress do you have? ◯Foam ◯Rubber ◯Cotton ◯Waterbed ◯Innerspring and Cotton ◯Other _____
Age of **Mattress**_____ **Pillow**_____ Allergy proof encasing ◯Yes ◯No

Mark appropriate box for the location in your home	**Plants**	**Ceiling Fan**	**Stuffed Animals**	**Bookshelves**	**Stuffed Furniture**	**Hard Surface Tile, Wood, etc.**	**Carpet**	**Age of carpet**
Patient bedroom	☐	☐	☐	☐	☐	☐	☐	☐
Living room	☐	☐	☐	☐	☐	☐	☐	☐
Family room	☐	☐	☐	☐	☐	☐	☐	☐
Other bedrooms	☐	☐	☐	☐	☐	☐	☐	☐
Other bedrooms	☐	☐	☐	☐	☐	☐	☐	☐
Hallways	☐	☐	☐	☐	☐	☐	☐	☐
Dining room	☐	☐	☐	☐	☐	☐	☐	☐
Other room	☐	☐	☐	☐	☐	☐	☐	☐

Pet History

Have you noticed any symptoms around animals?	◯ Yes	◯No
If so, describe _____		
Do you have any pets?	◯ Yes	◯No
Do any pets sleep in your bedroom?	◯ Yes	◯No
In your bed?	◯ Yes	◯No

Type	**#**	**Age**	**Inside**	**Outside**	**In & Outside**
Cat	☐	☐	☐	☐	☐
Dog	☐	☐	☐	☐	☐
Bird	☐	☐	☐	☐	☐
Other					
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐

General Medical Problems *Check the box if the symptom or diseases apply and describe as needed.*

Condition	**Notes (include any ailments not covered)**
☐ **Constitutional:** e.g. weight loss, fatigue, sleeping problems, fever chills	
☐ **Eye Problems:** e.g. glaucoma	
☐ **Ear, Nose, Throat, Mouth:** recurrent infections, hoarseness	
☐ **Cardiovascular:** e.g. angina, chest pain, heart attack, high blood pressure, arrhythmia, skipped heartbeats, palpitations, flutter, murmur, rheumatic fever, mitral valve prolapse (with regurgitation)	
☐ **Respiratory:** e.g. embolism, tuberculosis, coughed up blood	
☐ **GI:** e.g trouble swallowing, heartburn, reflux, frequent use of antacids, nausea, vomiting, diarrhea, constipation, cramping, abdominal pain, irritable bowel syndrome, hiatal hernia, peptic ulcer, gallbladder, liver problems, hepatitis	
☐ **Genitourinary:** e.g. frequency, pain on urination, blood in urine, recurrent urinary tract infections, prostate problems, slow stream of urine in men, kidney problems, cystic breast, biopsy, cancer, hysterectomy, ovaries removed	
☐ **Musculoskeletal:** e.g. arthritis (osteo rheumatoid) broken bones, osteoporosis, auto immune disorder	
☐ **Skin Problems:** e.g. rashes, acne, psoriasis	

Continued:

Condition	Notes (include any ailments not covered)
☐ **Neurological:** e.g.headache, numbness, tingling, pain, stroke, TIA	
☐ **Endocrine:** e.g. diabetes, thyroid disease	
☐ **Cancer:** type and treatment received	
☐ **Psychiatric/Emotional:** e.g. depression, eating disorders	
☐ **Hematologic Lymphatic:** e.g. anemia, enlarged lymph nodes	
☐ **Allergic/Immunologic:** see also page 1 & 7	
Other Ailment:	

Family History Allergy Is there a family history of allergy? *Check the box if yes*	**Children**	**Siblings**	**Mother's Parents**	**Father's Parents**	**Mother**	**Father**
Nose Allergy	☐	☐	☐	☐	☐	☐
Eye Allergy	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Hives	☐	☐	☐	☐	☐	☐
Eczema	☐	☐	☐	☐	☐	☐
Food Allergy	☐	☐	☐	☐	☐	☐
Migrane	☐	☐	☐	☐	☐	☐
Recurrent Pneumonia	☐	☐	☐	☐	☐	☐
Immune Disorder	☐	☐	☐	☐	☐	☐
Drug Allergy	☐	☐	☐	☐	☐	☐
Any Ailment not covered Specify_____	☐	☐	☐	☐	☐	☐

Family History General	**Children**	**Siblings**	**Mother's Parents**	**Father's Parents**	**Mother**	**Father**
Age at Death						
Arthritis	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Hypertension	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐

Geographic History

List your past several residences *City and State only*		**How long?**	**Effects on symptoms (better, worse or no change)**
Previous			
Previous			
Young Adult			
Childhood			
Place of Birth			

List any major illnesses, hospitalizations or surgeries you have had that has not been covered.

Please discuss any major or daily life stresses that you have experienced recently.

Please list any problems or concerns that you want to discuss with the allergist that have not been covered previously.

THANK YOU FOR TAKING THE TIME AND EFFORT TO FILL OUT THIS FORM AS COMPLETELY AND AS ACCURATELY AS POSSIBLE. YOUR INFORMATION WILL ALLOW US TO GIVE YOU THE APPROPRIATE CARE.

SAVE FORM SUBMIT FORM