Banner Health®

NEW PATIENT MEDICAL HISTORY
ADULT ALLERGY

Patient Name: _____ **Date of Birth:** _____

Please provide as much detail as you are able so that we can give you the safest and best care possible.

Preferred Pharmacy (name and location): _____

Primary Care Provider

Name: _____ Phone #: _____

Address: _____ Fax #: _____

Reason for visit (Check all that apply)

❑ **Nasal or Sinus Problems** ❑ **Skin Rash/Hives** ❑ **Chest Problems** ❑ **Food Allergies** ❑ **Frequent Infections**

___ Sneezing
___ Itching of:
- ___ Eyes
- ___ Ears
- ___ Nose
- ___ Palate (Roof of Mouth)
- ___ Clear Watery Nose

___ Puffy or Swollen Eyes
___ Watery Eyes
___ Stuffy Nose
___ Post Nasal Drainage/Throat Clearing
___ Frequent Raw Throat
___ Nasal Polyps
___ Frequent Headaches
___ Frequent Ear Infections
___ Sinusitis
___ Broken Nose
___ Mouth Breathing/Bad Breath
___ Trouble Breathing (Nasal/Sinus OR Chest)
___ Awaken at Night with Chest Symptoms
___ Wheezing When Breathing
___ Tightness in Chest
___ Frequent Cough
___ Wheezing with Exercise
___ Asthma
___ Pneumonia
___ Bronchitis

Other: _____

When did your symptoms begin? _____

When did you last have symptoms? _____

Have your symptoms ever limited your activity at school or work? ❑ Yes ❑ No If yes, explain: _____

_____

Have you lost time form school or work? ❑ Yes ❑ No If yes, explain: _____

_____

ALLERGIES

❑ **No Known Allergies** List any allergies and intolerances to **medications, food or the environment.**

Allergy	Reaction

Stinging Insect Allergy: ❑ Bee ❑ Wasp ❑ Yellow Jacket ❑ Fire Ant

Reaction: _____

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MEDICATIONS

❑ **Not taking any medications**

List any medications, vitamins, supplements, and over the counter medications you are taking, with dose and how often.

Medication Name	Dose	How often?

MEDICAL HISTORY

What **medical** problems have you had? Please mark **all** that apply:

	CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:		CONDITION:	ONSET DATE:
	Acute ear infections			Diabetes			Pleurisy	
	Allergic rhinitis			Eczema			Pneumonia	
	Asthma			Environmental allergies			Recurrent pneumonia	
	Atopic dermatitis			Heart disease			Sinusitis	
	Bronchitis			Hives			Sleep apnea	
	Cancer type: _____			Hypertension			Thyroid disease	
	Chronic cough			Immune disorder			Tonsillitis	
	Chronic ear infections			Immunodeficiency			Tuberculosis	
	Contact dermatitis			Nasal fracture			Other:	
	COPD			Nasal polyps				
	Deviated nasal septum			Pet allergies				

Other medical problems:

_____

_____

Have you had any recent hospitalizations or ER visits (provide dates and reason below)?

Date	Reason	Date	Reason

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SURGICAL HISTORY

List all prior surgeries and the date: ❑ **No prior surgeries**

Date	Type of Surgery	Date	Type of Surgery

FAMILY HISTORY

*Conditions Related to Allergy, Asthma & Immunology Only

Mother:	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Father:	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Sister(s):	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Brother(s):	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Children:	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema
Other family Members:	❑ Allergies/Hay Fever	❑ Asthma	❑ Hives	❑ Sinusitis	❑ Eczema

Any additional pertinent family history: _____

_____

SOCIAL HISTORY

Tobacco/smoking status: Never _____

Current _____ Type _____ Amount _____ Duration _____

Former _____ Type _____ Amount _____ Duration _____

Do you use alcohol? ❑ Yes ❑ No Type _____ Amount _____ Frequency _____

Do you use recreational drugs? ❑ Yes ❑ No Type _____ Amount _____ Frequency _____

Tobacco/smoking use in the home: ❑ Yes ❑ No

Do you exercise? ❑ Yes ❑ No If yes, list type of exercise and number of times/week: _____

Occupation _____ Employer _____

Do you have animals in the home? ❑ Yes ❑ No If yes, type: _____

HEALTH MAINTENANCE

List the last date given:

Flu:	Tdap (tetanus and /or diphtheria):
Pneumococcal:	Meningococcal:

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ALLERGY, ASTHMA & IMMUNOLOGY PERTINENT HISTORY

List geographic areas you have lived in and for how long:

Location	# of Years	Location	# of Years

Home Environment: ❑ House ❑ Duplex ❑ Condo ❑ Department ❑ Modular home **Years lived there:* _____

❑ Air conditioning ❑ Carpeting ❑ Down bedding ❑ Dusty hobbies _____ ❑ Forced air heat

❑ Previous flooding (Year: _____)

Have you ever been skin tested before? ❑ Yes ❑ No If yes, date: _____

Technique used: ❑ Pricked/scratched on the skin ❑ Injections into the skin

Have you ever been on allergy shots? ❑ Yes ❑ No If yes, date: _____

What medications have you found helpful for: (Specify name if known)

Nasal Problems:

❑ Antihistamines ❑ Nose drops ❑ Nasal steroid sprays ❑ Over the counter antihistamines ❑ Eye drops

Eye Problems:

❑ Antihistamines ❑ Over the counter antihistamines ❑ Eye drops

Chest Problems:

❑ Asthma inhalers ❑ Antihistamines ❑ Anti-Leukotrienes (Singulair, Accolate, Zyflo)

Skin Problems:

❑ Steroid creams ❑ Non-steroidal creams ❑ Over the counter creams ❑ Antihistamines

Please Note: Allergy Testing may be recommended at your first visit; please plan for a 2 hour visit. Additionally, stop taking oral antihistamine medications for at least 3 days prior to the visit. These include Benadryl (diphenhydramine), Zyrtec (cetirizine), Claritin (loratadine), Allegra (fexofenadine), Clarinex (desloratadine), Xyzal (levocetirizine), Atarax (hydroxyzine), Bromfed (Brompheniramine), Chlortrimeton (Chlorpheniramine) and Tavist-D.

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