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Name ________________________________DOB___/___/___ Age _____ Date _________

Primary Care Doctor ____________________________ City____________ __ None

Referring Physician _____________________________ City____________ __ Self-Refer

Insurance *Indicate PRIMARY with a "1" and SECONDARY with a "2"*
__Aetna __BCBS __BCBS HMO/PHAI __Cigna __Caterpillar __Coventry __Great West __Health Alliance HMO __Health Alliance PPO __HealthLink __Medicare __United Health
__Private Pay __Other______________________________

Pharmacy Information __30 Day Rx Preferred ___90 Day Rx Preferred
Usual Pharmacy________________________Location___________________
Mail-In Pharmacy_______________________Location/FAX_______________

Drug Allergies __ None __ See my DRUG ALLERGY LIST
Please include name of drug, reaction, and date: ___________________________________
____

Other Allergies __ None ____

Occupation_______________________________ How long at this job?________________

Communication of Results *Our automated system will contact you by phone and e-mail, if both are provided, when your results have been reviewed (if applicable). A PIN number will be required in order to retrieve your results. You may also view all results at your leisure on the patient portal. Our staff will assist you in gaining access to the portal. Please provide:*

Preferred Phone _______________________ Preferred E-mail________________________
May we leave information about your appointments/results on the phone/e-mail? __Yes __No

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Please complete the following form. Please ask our staff if you have any questions or need help.

What problems are you having at this time?

____

____

How long have you had the problem? **How many times or is it ongoing?**

______________________________ ____________________________________

What problems have you had in the past?

____

____

Does anything make the symptom better or worse, such as allergy triggers?

____

____

Expectations from this medical or allergy/asthma/immunology consultation?

____Allergy Testing ____

____Allergy Shots ____

RECENT MEDICAL EVALUATION:

Have you ever been evaluated by an allergist/immunologist? Yes____ No____

Doctor's Name:_________________ City/State:_________ Date last seen:_________

Have you seen an ENT surgeon? Yes___ No____ Have you had sinus surgery? Yes____ No____

Have you had any blood tests to see if you have allergies? Yes____ No____

Have you ever been skin tested to evaluate allergies? Yes____ No____

What were you allergic to?

Trees___ Grass___Weeds___ Corn Pollen___ Cat___Dog___Dust Mites___ Dust___

Mold___Roach___Foods________________ Other___________________________

Have you ever been on allergy shots? Yes____ No____ Duration______Last Shot______

Were shots helpful? Yes____ No____ Not sure_____

Did you have any reactions? No____ Yes_____Describe:________________

Have you had any recent blood work? No___ Yes___ Date?_________ Where?__________

Have you had any recent X-rays? Sinus X-ray___ Chest X-ray___ Sinus CT___ Head CT___

Chest CT____ Other____________________ Date?________ Where?__________

What other doctors have you seen for the problem? *List name, type of doctor, date*

____

Did you request records from another doctor sent here? No___ Yes___ Office?___________

MEDICATIONS ____See my MEDICINE LIST

List current medications or any changes/additions to your list, and reason for taking

1.____________________Reason:__________ 6.____________________Reason:_________

2.____________________Reason:__________ 7.____________________Reason:_________

3.____________________Reason:__________ 8.____________________Reason:_________

4.____________________Reason:__________ 9.____________________Reason:_________

5.____________________Reason:__________ 10.___________________Reason:_________

List over-the-counter (Tylenol, Aspirin), herbals, vitamins, medicated creams, and eye drops:
1.____________________Reason:__________ 5.____________________Reason:_________
2.____________________Reason:__________ 6.____________________Reason:_________
3.____________________Reason:__________ 7.____________________Reason:_________
4.____________________Reason:__________ 8.____________________Reason:_________

CURRENT MEDICAL PROBLEMS (Problem and date diagnosed)
1.____________________________________5. ____________________________________
2.____________________________________6. ____________________________________
3.____________________________________7. ____________________________________
4.____________________________________8. ____________________________________

Do you have any of the following?

Condition	No	Yes **	Not Sure	How long?	Severity/Comments
Allergy/Hay fever					Mild__Moderate__Severe__
Sinusitis					Mild__Moderate__Severe__
Eye Allergy					Mild__Moderate__Severe__
Asthma					Mild__Moderate__Severe__
Emphysema/ COPD					Mild__Moderate__Severe__
Lung Disease					Mild__Moderate__Severe__
Exercise-induced asthma					Mild__Moderate__Severe__
Hives/Urticaria					Mild__Moderate__Severe__
Swelling/ Angioedema					Mild__Moderate__Severe__
Rash/Eczema					Mild__Moderate__Severe__
Contact Dermatitis					Mild__Moderate__Severe__
Food Allergy					Mild__Moderate__Severe__
Drug Allergy					Mild__Moderate__Severe__
Insect Allergy					Mild__Moderate__Severe__
Vaccine Allergy					Mild__Moderate__Severe__
Anaphylaxis					Mild__Moderate__Severe__
Immune Problems					Mild__Moderate__Severe__

Headaches					Mild__Moderate__Severe__
Reflux/GERD					Mild__Moderate__Severe__
Autoimmune disease					Mild__Moderate__Severe__
Other (describe) _______________					Mild__Moderate__Severe__

**Additional Questions

PAST MEDICAL and SURGERY HISTORY ___See my HEALTH HISTORY LIST

1.____________________________________ 5.____________________________________
2.____________________________________ 6.____________________________________
3.____________________________________ 7.____________________________________
4.____________________________________ 8.____________________________________

Blood Products: Have you ever had a transfusion/infusion? No___ Yes___ When?___________
Sex History: Are you concerned about STDs? No___ Yes___ Why?_______________
Menstrual History: Regular__ Birth-control__ Post-Menopausal__ Hyst__ Irregular__ Problems__

Hospitalizations (Where, reason, date, and length of stay)

1.____________________________________ 3.____________________________________
2.____________________________________ 4.____________________________________

IMMUNIZATIONS ___See my SHOT RECORD

Are your immunizations up to date? Yes____ No____
Last Flu Shot _____________ Never____ Last Tetanus Shot ____________ Unsure____
Last Pneumovax / Prevnar (Pneumonia) Shot___________ Never____ Unsure____
Shingles Shot________________ Never____ Unsure____

FAMILY HISTORY

Immediate Family (Mother, Father, Siblings, Children):
Does anyone have asthma, hay fever, eczema, rash, food allergies, drug allergies, insect allergies, hives/angioedema, recurring and/or frequent infections? Please list and comment.

____

Extended Family: List any relevant health or hereditary diseases that seem to occur frequently in your family (diabetes, emphysema, heart problems, thyroid, arthritis, autoimmune disease).

____

ENVIRONMENTAL HISTORY:

Home: House____ Apartment____ Mobile Home____ Assisted-living____ Other_________
Age of Home:__________ Foundation: Basement___ Crawl-space___ Concrete___
Heat/cooling: Central____ Base-board____ Stove____ Radiator____ Window A/C___
Humidifier? Yes____ No____ HEPA filter? Yes____ No____
Do you keep your windows open or closed during nice weather? Open____ Closed___

Bedroom: Bed Age__________ Type: Synthetic____ Water____ Dust Mite Cover____
Pillow Age___________ Pillow Type: Synthetic____ Feather____ Dust Mite Cover____
Flooring in bedroom: Carpet____Age?_________ or Hard-surface____ Rugs_____
How many people live in the home: ___________ Who lives with patient?________________
Is there a second parent's home or after-school care?_________________________________
Are you exposed to smoke in the house? No____ Yes____ I smoke____ I don't smoke_____
Who smokes, if not you?____________________ In the house?________ In the car?_________
Do you ___Shower ___Bathe ___Daily ___Every other day ___Morning ___Evenings?

Frequent Animal Exposure: At my house_____ At someone else's house_____
Are the pets allowed inside the bedroom? Yes____ No____ Whose house?_________
Dogs___ Cats___ Rabbits___ Hamsters/Gerbils___ Ferrets___ Birds___ Horses___ Cattle___
Chickens___ Ducks___ Deer___ Roaches___ Ticks___ Fleas___ Mosquito___ Other________

Are you exposed to any allergens or chemicals at work, doing hobbies, or at home? *List.*
____
Do you wear any protection when working outdoors or at work? *List.*
____

SOCIAL HISTORY
Years in Illinois: _______________ Have you lived elsewhere?(Place/Time)_______________
Exercise (times/week): _______________ Type of exercise:____________________
Seatbelt use: 100%___ Often___ Never___ Helmet use: 100%___ Often___ Never____
Sun exposure: Alot___ Some___ Rare___ Sunscreen : Frequently___ Rarely____
Tobacco: Is the patient exposed to "passive smoke" from a family member? Yes___ No___

Social History: (Adults and Adolescents)
Caffeine (drinks/day):_____________ Type:______________________________
Tobacco: Never___ Yes___ Quit ___ Quit Date____________ Chew___ Vape___
Average packs per day?___________ How many years did you smoke?_________
Alcohol: Never___ Occas___ Daily___ Average drinks per week? ____ Type?_____________
Recreational drugs: Never___ Yes___ Past ___ Type?______________

Social History: (If patient <12 years old)
School: Yes____ Homeschool_____ Preschool/Daycare_____None____ Grade:__________
Performance: Excellent___ Good___ Fair___ Poor___ Sports/Activities:________________

Birth History: (If patient <5 years old)
Birthplace (city/state):______________________ Birth Weight:_________ Full term: Yes__ No__
Type of birth: Vaginal_____ C-Section _____ NICU stay?________ Ventilator?________
Breast fed: Yes___ No___ If "yes", for how long:__________________
Formula type: Milk____ Soy___ Nutramigen___ Alimentum___ Elecare ____ Neocate_____
List problems with breastfeeding or formula:____
Age started solid foods:__________ List problems with food/stool:________________________

Additional Comments:

ADDITIONAL ALLERGY QUESTIONNAIRE: Rhinitis, Sinusitis, Chronic Sinusitis

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Do you have daily symptoms: Yes ____No _____ Problems are: Year-Round____Seasonal ____
Timing: Worse than in Spring___ Summer____ Fall____ Winter____
Are your allergy symptoms: Getting worse____Getting better____ Constant____ Unchanged____
Check all allergy symptoms:

Eyes	Ears	Nose	Sinus /Head	Throat
___Itch ___Swelling ___Burning ___Pain ___Runny ___Watery ___Discharge ___Blurry vision ___Double vision ___Infections ___Other	___Itch ___Fullness ___Popping ___Decreased hearing ___Pain ___Feeling of fluid ___Infections ___Other	___Itch ___Sneezing ___Multiple sneezes ___Bleeding ___Stuffy nose ___Runny nose ___Clear discharge ___ Colored discharge ___Poor smell ___Mouth breathing ___Polyps ___Other	___Facial Pain ___Pressure ___Headache ___Dryness ___Concentration problems ___Sleep problems ___Fatigue ___Sinusitis ___Frequent infections ___ Other	__Itch __Drainage __Mucus __Burning __Pain __Swelling __Swallowing problems __Hoarse __Clearing __Clicking __Large glands __Infections __Cough __Bad taste __Acid taste __Bad breath __Other

Check all allergy triggers:

___Cats ___Dusting ___Indoors ___Smoke ___Being at Home
___Dogs ___Cleaning ___Outdoors ___Perfume ___Being at Work
___Horses ___Cold Air ___Eating ___Odors ___Mornings
___Grass ___Humidity ___Alcohol ___Being Hot ___Evenings
___Yardwork ___Wind ___Exercise ___Being Cold___Nighttime/Lying down
Foods (list):_____________ Medication (list):_________ ___Other:

Have you ever been on “immunotherapy” for your symptoms? Yes____ No____ Uncertain____
____Allergy shots ____Sublingual allergy drops

Treatments you have tried: *Please check.*
Allergy pills: __Loratadine/Claritin/Alavert __Cetirizine/Zyrtec __Fexofenadine/Allegra
__Benadryl __Hydroxyzine __Montelukast/Singulair __Zafirlukast/Accolate __Sudafed
Nose sprays: __Fluticasone/Flonase __Triamcinolone/Nasacort __Flunisolide __Nasonex
__Beconase __Rhinocort __Veramyst __Omnaris __Qnasl __Zetonna __Dymista __Patanase
__Azelastin (Astelin/Astepro) __Afrin __Vicks Spray __Mucinex __Wal-Four __Dristan
Saline: __Saline Spray __NettiPot __NeilmedRinse __NasalMist
Eyedrops: __Ketotifen(Alaway/Zaditor/Zyrtec or Claritin Eye Drops) __Patanol/Pataday __Pazeo

__Bepreve __Azelastine/Optivar __Elestat __Opcon/Naphcon/Visine __Similasan

ADDITIONAL PULMONARY QUESTIONNAIRE: Asthma, COPD/Emphysema, Lung Problems

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Onset of Symptoms (age): _____________ Do you have daily symptoms: Yes ____No _____
Timing: Year-Round____Seasonal ____ Worse in Spring___ Summer____ Fall____ Winter_____
Is your breathing: Getting worse___ Getting better___ Constant____ Unchanged_____

Check all chest symptoms:

__Asthma
__Emphysema/COPD
__Chronic Bronchitis
__Bronchiectasis, Diagnosed when?__________
__History of Histoplasmosis, When?____
__Pulmonary hypertension
__History of Blood Clot/PE, When?____
__Other:_________________
__Cough __Wheeze, Onset:__________
__Cough/Wheeze at Night, Onset:___________
__Cough/Wheeze with Activity
__Cough/Wheeze with Laughing
__Chest tightness __Chest Pain
__Shortness of Breath __Trouble with Activity
__Woken up by symptoms
__Mucus production ___Clear ___Colored
__Frequent infections ___Pneumonia, How many times?__________ When?___________
___Bronchitis, How many times?____________When?___________

Check all triggers:

___Cats ___Yardwork ___Dusting ___Indoors ___Smoke ___Being at Home
___Dogs ___Wind ___Cleaning ___Outdoors ___Perfume ___Being at Work
___Horses ___Exercise ___Cold Air ___Eating ___Odors ___Mornings
___Grass ___Humidity ___Alcohol ___Being Hot ___Being Cold___Evenings
___Nighttime/Lying down Other:________Foods (list):________ Medication (list):_________

Have you had a chest X-ray? Yes__ No__ Chest CT? Yes__ No__ Date/result?____________
Have you had lung function testing? Yes___ No___ Date/results:_________________________
Have you ever been on a ventilator? Yes____ No____ Admitted to the ICU? Yes____ No____
How many times (lifetime) have you been on steroids:_______ Last course of steroids:_________
Have you had a Bone Density test? Yes____No____ Osteopenia/Osteoporosis? Yes____No____
Do you currently use "rescue medicine/albuterol"? Yes___ No___ Nebulizer___ Meter Inhaler____
times per week you use rescue?_____ Use of rescue at night Yes__ No__ # times?_____
Do you have smoke exposure? Yes___ No___ Do you have a wood burning stove? Yes___ No___
Have you been screened for Alpha-1 Antitrypsin Deficiency (genetic emphysema)? Yes___ No___
Would you like a complimentary screening today? Yes___ No___

Treatments you have tried: *Please check.*

Inhalers: __Flovent __Pulmicort __Asmanex __Qvar __Alvesco __Aerospan __Arnuity __Advair __Dulera __Symbicort __Breo __Foradil __Serevent __Stiverdi __Spiriva __Tudorza __Anoro __Combivent __Albuterol __Xopenex

Nebulizers: __Brovana __Performist __Budesonide (Pulmicort) __Albuterol __Xopenex __Duoneb __Ipatroprium (Atrovent) __N-Acetylcysteine

Pills: __Singulair __Accolate __Theophylline __Daliresp __Mucinex __Pulmozyme

Other: __Xolair __Oxygen __CPAP __Pulmonary Rehab List:_________________________

Did they help your breathing? Yes___ No___ Uncertain___ What was most effective?_________

Please answer if you have or your child has ASTHMA:

Do you use a peak flow meter? Yes____ No____ Best peak flow (liters/min):_____________

Do you have an Asthma Action Plan? Yes___ No____

Do you want more information about a peak flow meter / Asthma Action Plan? Yes___ No___

ASTHMA CONTROL TEST (12 years and up) *Score <19 suggests that Asthma needs addressed.*

In the past 4 weeks, how much did your asthma keep you from getting as much done at work, school or home?

1. All of the time 2. Most of the time 3. Some of the time 4. A little of the time 5. None of the time

During the past 4 weeks, how often have you had shortness of breath?

1. More than once a day 2. Once a day 3. 3-6 times a week 4. 1-2 times a week 5. Not at all

During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness or pain) wake you up at night or earlier than usual in the morning?

1. 4 or more nights a week 2. 2-3 nights a week 3. Once a week 4. Once or twice 5. Not at all

During the past 4 weeks, how often have you used your rescue inhaler or neb (such as albuterol)?

1. 3 or more times per day 2. 1-2 times per day 3. 2-3 times per week 4. Once a week or less 5. Not at all

How would you rate your asthma control during the past 4 weeks?

1. Not Controlled 2. Poorly Controlled 3. Somewhat Controlled 4. Well Controlled 5. Completely Controlled

ASTHMA CONTROL TEST (4-11 years) *Score <19 suggests that Asthma needs addressed.*

How is your asthma today? 0. Very bad 1. Bad 2. Good 3. Very good

How much of a problem is your asthma when you run, exercise or play sports?

0. It's a big problem, I can't do what I want to do. 1. It's a problem and I don't like it.
2. It's a little problem but it's okay. 3. It's not a problem.

Do you cough because of your asthma?

0. Yes, all of the time. 1. Yes, most of the time. 2. Yes, some of the time. 3. No, none of the time.

Do you wake up during the night because of your asthma?

0. Yes, all of the time. 1. Yes, most of the time. 2. Yes, some of the time. 3. No, none of the time.

During the last 4 weeks, how many days did your child have any daytime asthma symptoms?

5. Not at all 4. 1-3 days 3. 4-10 days 2. 11-18 days 1. 19-24 days 0. Everyday

During the last 4 weeks, how many days did your child wheeze during the day because of asthma?

5. Not at all 4. 1-3 days 3. 4-10 days 2. 11-18 days 1. 19-24 days 0. Everyday

During the last 4 weeks, how many days did your child wake up during the night due to asthma?

5. Not at all 4. 1-3 days 3. 4-10 days 2. 11-18 days 1. 19-24 days 0. Everyday

Please answer below for Sleep Apnea Screening.

0 = no chance of dozing 1 = slight chance of dozing 2 = moderate chance of dozing 3 = high chance of dozing

Sitting and reading _____________

Watching TV _____________

Sitting inactive in a public place (e.g a theater or a meeting) _____________

As a passenger in a car for an hour without a break _____________

Lying down to rest in the afternoon when circumstances permit _____________

Sitting and talking to someone ____________
Sitting quietly after a lunch without alcohol ____________
In a car, while stopped for a few minutes in traffic ____________

ADDITIONAL SKIN QUESTIONNAIRE: Eczema, Hives, Swelling/Angioedema, Itch, Rash

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When did your rash first start?_________________________ Age at onset? __________________
Where do you have the rash? _________________________Where did it first appear?__________
Do you have daily symptoms? Yes ____ No _____ Timing: Year-Round____Seasonal ____
Have you had the rash before? Yes ____ No _____ Spring___Summer___Fall___Winter___
Is your skin/rash: Worse___ Better___ Constant____Comes & Goes___ Unchanged____
Do you have a dermatologist? Yes____ No____ Name:__________________________________

What do you think causes your rash?____
What size are the individual rash spots?____
Is there any pattern that your rash follows? (Describe)___________________________________
The rash is (describe):____

ITCHES: Yes ____ No____ Uncertain____
BRUISES: Yes ____ No____ Uncertain____ Spontaneously____ After scratching____
PAINFUL: Yes ____ No____ Uncertain____
FEATURES: Flat____ Raised____ Blistered____ With Swelling____ Red____ Purple____
Other___________________________
DURATION: Minutes to Hours_____ Hours to Days_____ Weeks_____ Months____
WORSE: In the AM____ In the PM____ At Night____ No Change Day or Night____
After Eating____ Which foods?___________________________________
After Drinking Alcohol_____ Which?________________________________
Around Pets____ Which?____
After Exercise____After Sweating___ After Hot Showers____ With Sun____
During Cold Weather____ After Being Cold____ After Swimming____
After Yardwork____ After Housework____
Outdoors___ Indoors____ Home___ Work___ School___ Vacation___
With Stroking/Rubbing____ With Tight Clothing____ With Vibration____
With Emotional Stress______ Other____________________________

Have you had:

Skin Infection / Antibiotics / Anti-fungal? Yes____ No____ Which/When?______________
Skin Biopsy? Yes____ No____ Results:_____________________________________
Skin Sensitivity? Fragrance____Metals____Sulfates____Parabens____Formaldehyde____
Wool___Latex___Rubber___Adhesive___Neomycin___Benzalk____Other________
Travel Abroad just before the rash started? Yes____ No____ Where/When?____________
New Medicines just before the rash started? Yes____ No____ Which/When?___________
Discontinuation of any medicines? No___ Yes___ Which?___________ How long?_______

Have you been evaluated for food allergy? Yes____ No____ Which/When?__________________
Have you had any of the following symptoms associated with your rash?

Excessive sweating___ Diarrhea___ Headaches___ Abdominal cramps___ Fever___
Muscle pains___ Joint swelling___ Joint pain/stiffness___ Fatigue___ Other_____________

What other skin conditions have you had? List:______________________________________

Eczema / Atopic Dermatitis____ Diagnosed when?______________ Contact Dermatitis___

Hives / Angioedema___ Seborrheic Dermatitis___ Vitiligo___ Alopecia___ Lupus___

ADDITIONAL SKIN QUESTIONNAIRE (Page 2)

Skin Care

What medications have you used to control your rash?

ORAL STEROIDS No___ Yes___ How many times?_________ When?_________________

1.________________________________ Effective____ Not effective____ Currently Using___

2.________________________________ Effective____ Not effective____ Currently Using___

ORAL IMMUNOSUPPRESSANTS No___ Yes___ When?_____________________________

1.________________________________ Effective____ Not effective____ Currently Using___

2.________________________________ Effective____ Not effective____ Currently Using___

TOPICAL MEDICATED CREAMS No___ Yes___

1.________________________________ Effective____ Not effective____ Currently Using___

2.________________________________ Effective____ Not effective____ Currently Using___

3.________________________________ Effective____ Not effective____ Currently Using___

4.________________________________ Effective____ Not effective____ Currently Using___

ORAL ANTI-HISTAMINES / ANTI-ITCH No___ Yes___

1.________________________________ Effective____ Not effective____ Currently Using___

2.________________________________ Effective____ Not effective____ Currently Using___

3.________________________________ Effective____ Not effective____ Currently Using___

4.________________________________ Effective____ Not effective____ Currently Using___

MOISTURIZERS? No___ Yes___

1.________________________________ Effective____ Not effective____ Currently Using___

2.________________________________ Effective____ Not effective____ Currently Using___

3.________________________________ Effective____ Not effective____ Currently Using___

4.________________________________ Effective____ Not effective____ Currently Using___

List if Applicable:

Shampoo______________________ Conditioner_________________________

Soap_________________________ Body Wash_________________________

Bubble Bath___________________ Diaper_____________________________

Dish Soap_____________________ Rinsing Agent_______________________

Laundry Soap__________________ Fabric Softener______________________

Make-up______________________ After-Shave_________________________

Deoderant_____________________ Fragrance/Cologne___________________

Soap At Work__________________ Air Fresheners_______________________

Other Chemical Exposures____

Hobbies that might exposure you to chemicals or allergens (electronics, construction, jewelry, etc):

____

ADDITIONAL QUESTIONNAIRE: Food allergy and digestive problems

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Onset of Symptoms (age): _____________ Do you have daily symptoms: Yes ____No _____
If you are an adult, did you have food allergies as a child? Yes__ No__ Unsure__
Do you have Eosinophilic Esophagitis? Yes__ No__ Unsure__
Do you have Food-Induced Eczema? Yes__ No__ Unsure__
Do you have Food-Induced Allergy/Congestion/Asthma? Yes__ No__ Unsure__
Timing: Year-Round____Seasonal ____ Worse in Spring___ Summer____ Fall____ Winter
Are your problems: Getting worse___ Getting better___ Constant____ Past____

Food Allergy:
Symptoms associated:

Skin Hives__ Swelling__ Rash__ Eczema__
Head/Mouth Runny Nose__Itchy Eyes__ Congestion__ Throat Clearing__
Tongue Swelling__ Mouth Sores__ Mouth/Throat Itchy__ Headache__
Fogginess__ Poor Concentration__ Hyperactive__ Sleepy/Tired__
Breathing Chest Tightness__ Cough__ Wheezing__ Aspiration__
Vascular Dizziness__ Fainting__ Low Blood Pressure__ Heart Racing__
GI Nausea__ Vomiting__ Acid Reflux__ Diarrhea__ Constipation__ Bloating__
Belching__ Flatulence__ Abdominal Pain/Cramping__ Choking__
Food Getting Stuck__ Pain on Swallowing__ Slow-eater__ Slow-Chewer__
Joints Joint Swelling__ Joint Pain__ Extremity Swelling__

Suspected Food: ______________________ Date/Age:_________ Reaction:__________________
Suspected Food: ______________________ Date/Age:_________ Reaction:__________________
Suspected Food: ______________________ Date/Age:_________ Reaction:__________________

I have a diagnosed food allergy. Yes__ No__ Diagnosed when?__________________
How? Blood Test__ Skin Test__ Other ________________ By Who?______________

1. Food: ________________ Date/Age:_________ Reaction:___________________________
2. Food: ________________ Date/Age:_________ Reaction:___________________________
3. Food: ________________ Date/Age:_________ Reaction:___________________________
4. Food: ________________ Date/Age:_________ Reaction:___________________________

Do you/your child have a Food Anaphylaxis Action Plan? Yes___ No___ Need one? Yes__ No__

Do you have emergency EPINEPHRINE (EpiPen, EpiPen Jr, AuviQ, Adrenaclick)? Yes___ No___
Have you ever used or received epinephrine? Yes____ No____ When?________________
Have you ever visited the ER for an allergic reaction? Yes____ No____ When?_________
Have you ever been hospitalized for an allergic reaction? Yes____ No____ When?_______
Are you taking a BETA BLOCKER or ACE-INHIBITOR category of medicine?
Yes____ No____ (These types of medicines sometimes interfere with Epinephrine).

ADDITIONAL QUESTIONNAIRE: Drug / Insect / Vaccine and Other Allergy problems

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Onset of Symptoms (age): _____________ Do you have daily symptoms: Yes ____No _____
Timing: Year-Round____Seasonal ____ Worse in Spring___ Summer____ Fall____ Winter
Are your problems: Getting worse___ Getting better___ Constant____ Past____

Tell Us About the Problem:

____

____

Drug Allergy: (Include Vaccines, Anaesthetics, Contrast Dye)

Do you have an Aspirin allergy? Yes__ No__ Unsure__
Do you have a Nonsteroidal Agent (NSAID) allergy? Yes__ No__ Unsure__

1. Drug: ________________ Date/Age:_________ Reaction:__________________________
2. Drug: ________________ Date/Age:_________ Reaction:__________________________
3. Drug: ________________ Date/Age:_________ Reaction:__________________________
4. Drug: ________________ Date/Age:_________ Reaction:__________________________
5. Drug: ________________ Date/Age:_________ Reaction:__________________________
6. Drug: ________________ Date/Age:_________ Reaction:__________________________
7. Drug: ________________ Date/Age:_________ Reaction:__________________________
8. Drug: ________________ Date/Age:_________ Reaction:__________________________
9. Drug: ________________ Date/Age:_________ Reaction:__________________________
10. Drug: ________________ Date/Age:_________ Reaction:__________________________

Insect Allergy:

Have you ever had a large or “life threatening” reaction to a stinging insect? Yes_____ No_____
Date_________ Suspected insect______________ Reaction___________________

Do you have emergency EPINEPHRINE (EpiPen, EpiPen Jr, AuviQ, Adrenaclick)? Yes___ No___
Have you ever used or received epinephrine? Yes____ No____ When?________________
Have you ever visited the ER for an allergic reaction? Yes____ No____ When?_________
Have you ever been hospitalized for an allergic reaction? Yes____ No____ When?_______
Are you taking a BETA BLOCKER or ACE-INHIBITOR category of medicine?
Yes____ No____ (These types of medicines sometimes interfere with Epinephrine).

ADDITIONAL QUESTIONNAIRE: Immune problems

Onset of Symptoms (age): _____________ Do you have daily symptoms: Yes ____No _____
Timing: Year-Round____Seasonal ____ Worse in Spring___ Summer____ Fall____ Winter
Are your problems: Getting worse___ Getting better___ Constant____ Past____

Immunology Evaluation:
Have you ever been diagnosed with a primary immunodeficiency? No___ Yes___
Describe: ____
Have any family members ever been diagnosed with an immunodeficiency? No___ Yes___
Describe: ____
Have you ever been diagnosed with any of the following:
Pneumonia___ Meningitis___ Osteomyelitis___ Sepsis___ Recurrent UTI___
Bronchiectasis___ Chronic Bronchitis
Neutropenia___ Low Platelets____ Recurrent Pharyngitis___
Persistent Lymph Nodes/Swollen Glands___ Delayed Umbilical Cord Separation___
Severe Skin Infection___ Abscesses___
Cystic Fibrosis___ Complement deficiency___ IgA deficiency___ HIV___ AIDS___
Antibody deficiency___ Common Variable Immunodeficiency___ Other: _______________

How many times have you had pneumonia? ______________ How many per year? ___________
How many sinus infections have you had in your life? _______ How many per year? ___________
How many ear infections have you had in your life? __________ How many per year? _________
How many throat infections have you had in your life? __________ How many per year? _______
Have you ever been evaluated for primary immunodeficiency? Yes____ No____
Have you ever been tested for HIV? Yes___ No___ If "yes", last date and result:______________
Have you ever received intravenous immunoglobulin (IVIG) or subcutaneous IG?
Have you ever received allergy shots or allergy drops? (Known as subcutaneous immunotherapy, SCIT, or sublingual immunotherapy, known as SLIT)? No___ Yes____
Describe: ____