ALLERGY & ASTHMA MEDICAL CARE CENTER

BOARD CERTIFIED ALLERGY & ASTHMA CARE SPECIALISTS

☐ 896 TARGEE STREET, STATEN ISLAND, NY 10304

☐ 159 CLINTON STREET, BROOKLYN NY 11201

WWW.TREATMYALLERGY.COM

Name:_____

_____

Date of Birth: __/__/___

Gender: _____

Date:

NEW PATIENT INFORMATION

(Patients Please complete this side)

Full name: _____
(First Name and Last Name)

Referred By: _____

1. Please describe the reason for your visit:

_____

_____

_____

_____

_____

_____

_____

2. When did this first occur? _____

3. How frequent is this problem? _____

4. Is it present all year round or at certain times of the year? _____

5. What improves this problem/makes it better?

_____

_____

6. What worsens this problem/makes it worse?

_____

_____

(Circle all triggers that makes it worse)

Dust	Mold	Cigarettes
Feathers	Animals	Weather changes
Grass	Trees	Weeds
Heat	Cold	Exertion
Excitement	Perfume	Hair Spray
Strong Odors	Foods:_____	

7. Have you ever had allergy skin testing or shots?

(Yes / No **)**

(This Section for Physicians only)

History of Present Illness:

Name:_____

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8. Do you/(the patient) have or had any of the following conditions? (Circle all that apply)

Asthma	Wheezing	Shortness of Breath
Cough	Sneezing	Bronchitis
Runny Nose	Stuffy Nose	Post Nasal Drip
Itchy Nose	Hay Fever	Sinus Infections
Itchy Eyes	Red Eyes	Watery Eyes
Eczema	Hives	Insect Allergies
Itchy skin	Pneumonia	Facial Swelling

Drug Allergies: _____

Food Allergies: _____

Other: _____

9. Have you/(the patient) missed school or work because of this problem? (Yes / No **)**

10. What type of place do you/(the patient) live in?

House Condo Apartment

Other: _____

11. How is the residence heated?

Forced Hot Air Radiator / Baseboard

12. Is there air conditioning?

Window Central No

13. Are there any pets? (Yes / No **)**

If yes, describe: _____

14. Is there any mold or water damage? (Yes / No **)**

If yes, describe: _____

15. Is there carpeting? (Yes / No **)**

If yes, describe: _____

16. Does anyone at this home smoke? (Yes / No **)**

If yes, describe: _____

(This Section for Physicians Only)

Atopic History Review:

Environmental Review: (Include Work/School)

Name:_____

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17. Does anyone in the family have similar symptoms, or any of the following?

Hay Fever Asthma Bronchitis

Food Allergy Drug Allergy Insect Allergy

GI problems Eczema Sinus Problems

Describe:_____

_____

18. Please list any other medical conditions you / (or the patient) have, and any surgical procedures:

_____

_____

_____

_____

19. Pleases list any medications, supplements or vitamins you / (the patient) are taking: (Doses Also)

_____

_____

_____

_____

_____

_____

20. Do you / (the patient) have any drug allergies, including Penicillin and Aspirin? (Yes / No **)**

If yes, describe: _____

_____

_____

21. Do you / (the patient) have any other allergies you are aware of?

_____

_____

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Family History:

Past medical history:

Known Allergies: ☐ No Known Drug Allergies

Name:_____

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(Patients Please complete this side)

22. Do you / (the patient) have any of the following symptoms on a regular basis? (Circle all that apply)

Fever	Chills	Weight loss
Weight Gain	Fatigue	Appetite loss
Eye Pain	Blurry Vision	Red Eyes
Watery Eyes	Itchy Eyes	Vision Loss
Sneezing	Itchy Nose	Sinus Problems
Nose Bleed	Runny Nose	Stuffy Nose
Sore Throat	Trouble Swallowing	
Ear Pain	Clogged Ears	Problems with Hearing
Wheezing	Cough	Chest Tightness
Snoring	Shortness of Breath	
Chest Pain	High blood pressure	
Nausea	Vomiting	Diarrhea
Constipation	Heartburn	Abdominal Pain
Increased Urination		Blood in Urine
Joint Pain	Weakness	Joint Swelling
Stiffness	Muscle Pain	Numbness
Dizziness	Headache	Seizures
Anxiety	Depression	Stress
Anemia	Easy Bruising	Easy Bleeding
Increased Thirst		Heat or Cold Intolerance
Dry Skin	Itchy Skin	Hives
Dark spots on skin		Food reactions
Drug Reactions		Skin Problems
Immune Problems		Anaphylaxis

Other Issue: _____

23. Please Sign and then return this form to front Desk. (Do not fill out any further after this)

X_____

(This Section for Physicians Only)

Review of Systems:

General: ☐Negative

Eyes: ☐Negative

ENT: ☐Negative

Respiratory: ☐Negative

Cardiovascular: ☐Negative

GI: ☐Negative

GU: ☐Negative

Musculoskeletal: ☐Negative

Neuro: ☐Negative

Psych: ☐Negative

Heme: ☐Negative

Endocrine: ☐Negative

Allergy: ☐Negative

Other: ☐Negative