Kentuckiana Allergy New Patient Form

Name: _____ Date of Birth: _____ Today's Date: _____

Current Email: _____

CURRENT, RECURRENT, OR RECENT SYMPTOMS (please circle): Problems for _____ days / wks / mo / yrs

Constitutional: Unexplained weight loss or weight gain Fever Malaise Fatigue
Neurologic: Headaches Migraines Vertigo Dizziness
Eyes: Itching Watery Red Mucus Puffiness Dark Circles Vision Changes
Ears: Ringing Fullness Hearing Loss Ear Tubes
Nose: Congestion Runny Nose Sneezing Itching Sinus Pain Loss of Smell
Mouth: Sore Throat Postnasal Drip Itching Throat clearing/swelling Snoring Mouth Breathing
Heart: Chest Pain Irregular Heartbeat Palpitations Cardiovascular disease
Lungs: Congestion Wheezing Cough Shortness of Breath Problems Exercising Tightness
Gastric: Vomiting Diarrhea Nausea Reflux Cramping
Skin: Itching Rash Hives Swelling Eczema
Hematologic: Anemia Easy Bruising Bleeding Skin Pallor
Immunologic: Recurrent Infections (>3 in past year) => Ear Sinus Lungs Skin GI other
Endocrine: Excessive Thirst Heat/Cold Intolerance Thyroid Problems

CURRENT MEDICATIONS (prescription and over the counter) - PLEASE CIRCLE Strength / Dose

Flunisolide Flonase Nasocort Nasonex QNasl Veramyst Zetonna Dymysta _____
Astepro Astelin Patanase _____
Advair Asmanex Dulera Flovent Pulmicort Symbicort QVar _____
Albuterol Inhaler / Neb ProAir Proventil Ventolin Xopenex Inhaler / Neb _____
Allegra / Fexofenadine Atarax / Hydroxyzine Benadryl / Diphenhydramine _____
Clarinex / DesLoratidine Claritin / Loratidine Xyzal / Levocetirizine Zyrtec / Cetirizine _____

Name of other Medications: Strength / Dose Times per day Last dose (date)

_____
_____
_____
_____
_____
_____
_____

MEDICAL HISTORY (please circle):

Nasal allergies	Sinus infection	Acid reflux	Thyroid disease
Anaphylaxis	COPD/emphysema	Kidney problems	HIV/AIDS
Asthma	Sleep apnea	Arthritis	Rheumatic fever
Eczema	Cancer	Migraine headaches	Tuberculosis or TB test (+)
Pneumonia	Angina	Seizures/epilepsy	RSV (bronchiolitis)
Latex allergy	High blood pressure	Stroke	Lupus
Nasal polyps	Heart murmur	Anemia	Depression
Hives/Angioedema	Heart attack	Blood transfusions	Born Premature
Immune deficiency	Heart arrhythmia	Bleeding disorder	Panic/anxiety
Glaucoma	Colitis	Diabetes	Other_____

Hospitalizations / Surgeries / Dates _____

_____

Drug Allergies - Yes / No (Briefly Describe):_____

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Triggers that make your symptoms worse: (worse with / around / during)

_Cats	_Moldy areas	_Weather changes	_Outdoors	_Nighttime
_Dogs	_Strong odors (fragrance, cleansers)	_Cold weather	_Exercise	_in the AM
_Other animals	_School/Work environment	_Hot weather	_Tobacco smoke	
_Dust	_Air pollution	_Damp weather	_Pollen	
_Mowed grass	_Anxiety/stress	_Dry weather	_Foods _____	

List Food Allergies _____

Venom reactions: (Circle all that apply) Bees, Wasps, Yellow Jackets, Hornets, Fire Ants, and/or Latex?

Symptoms: Breathing Trouble Skin GI Fainting Other_____

Previous Allergy Testing: (when)_____Positive to: Dust Mold Cats Dogs Trees Grass Weeds

Have you ever taken Allergy Shots: (when)_____Did they help: Y / N / Maybe , Severe Reactions: Y / N

Social History: (please circle)

Single Married Divorced Domestic Partner Widowed

Never smoked Currently Smoke Quit smoking____Yrs ago Packs/day___ # of years____

Smokers in Home Yes / No Inside / Outside

Do you drink alcohol? Yes / No How often: Daily Weekly Monthly Rarely

Do you use recreational drugs? Yes / No How often: Daily Weekly Monthly Rarely

Pets at home: #Cats____#Dogs____other_____ Occupation: (past/present) _____Retired

School/Grade: _____ Daycare: Yes / No Private Sitter: Yes / No

Live in: House / Apartment / Mobile Home Age of Home: (yrs) ____ Basement: Y / N Central Air: Y / N

Family History: (please Circle and write M-Mother, F-Father, S-Sister, B-Brother, C-Child, O-Other Family):

Nasal Allergies _____ Eye Allergies _____ Asthma _____ COPD _____ Sinus Problems _____

Eczema _____ Food Allergies _____ Hives _____ Angioedema (swelling) _____ Cancer _____

Drug Allergy _____ Immune Deficiency _____ Migraine Headaches _____ Autoimmune Prob _____

Cystic fibrosis _____ Diabetes _____ Heart Disease _____ Hypertension _____

Other_____

Immunizations: Up to Date: Yes / No Reactions to Immunizations: Yes / No describe)_____

Last Tetanus _____ Last Flu vaccine _____ Last Pneumovax (year) _____

Primary Care Doctor_____ Pharmacy name / ph# _____

Other Doctors who care for you: _____

Other family members who are patients here: (name/relationship) _____

_____