

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 (briefly 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 migraine 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?	<input type="radio"/> Yes <input type="radio"/> No	List positive results			
RAST blood testing?	<input type="radio"/> Yes <input type="radio"/> No	List positive results			
Did you receive allergy shots?	<input type="radio"/> Yes <input type="radio"/> No	Treatment dates			
Ear, Nose & Throat Doctor		Address		Phone	
				Fax	
Ear, Nose or Throat surgery?	<input type="radio"/> Yes <input type="radio"/> No	List procedures and dates			

Procedures

Have you had in the past 12 months:		If so, when & where was it done?	Results
Physical	<input type="radio"/> Yes <input type="radio"/> No		
Blood Work	<input type="radio"/> Yes <input type="radio"/> No		
Have you ever had the following?			
Pulmonary Function	<input type="radio"/> Yes <input type="radio"/> No		
Sinus C T	<input type="radio"/> Yes <input type="radio"/> No		
Chest X-ray	<input type="radio"/> Yes <input type="radio"/> No		
HIV test	<input type="radio"/> Yes <input type="radio"/> No		
TB test	<input type="radio"/> Yes <input type="radio"/> No		
Hepatitis	<input type="radio"/> Yes <input type="radio"/> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other outdoor activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High winds or riding in auto with open windows	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping, dusting or using a vacuum cleaner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moldy or mildewed areas or articles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact or nearness to animals Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Household cleaning agents (laundry soaps, detergents etc.). Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strong odors Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air conditioning at home or places you visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Following rainfall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trips away from home Specify area and time of year _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smoke or smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of hair spray, tint cosmetics, perfumes, deoderants, after shave lotions, etc. Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional upsets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heavy physical exertion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Anything else you have noticed (seasonal) Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal Congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Runny Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Post Nasal Drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Itchy Nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ear Problems	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cough or Wheeze with exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Short of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Infections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Fatigue	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Living room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Family room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other bedrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other bedrooms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hallways	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dining room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other room	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dog	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bird	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
	<input type="text"/>	<input type="text"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

Condition	Notes (include any ailments not covered)
<input type="checkbox"/> Constitutional: e.g. weight loss, fatigue, sleeping problems, fever chills	
<input type="checkbox"/> Eye Problems: e.g. glaucoma	
<input type="checkbox"/> Ear, Nose, Throat, Mouth: recurrent infections, hoarseness	
<input type="checkbox"/> Cardiovascular: e.g. angina, chest pain, heart attack, high blood pressure, arrhythmia, skipped heartbeats, palpitations, flutter, murmur, rheumatic fever, mitral valve prolapse (with regurgitation)	
<input type="checkbox"/> Respiratory: e.g. embolism, tuberculosis, coughed up blood	
<input type="checkbox"/> 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	
<input type="checkbox"/> 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	
<input type="checkbox"/> Musculoskeletal: e.g. arthritis (osteo rheumatoid) broken bones, osteoporosis, auto immune disorder	
<input type="checkbox"/> Skin Problems: e.g. rashes, acne, psoriasis	

Continued:

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

Family History Allergy Is there a family history of allergy? <i>Check the box if yes</i>	Children	Siblings	Mother's Parents	Father's Parents	Mother	Father	Family History General	Age at Death	Children	Siblings	Mother's Parents	Father's Parents	Mother	Father
Nose Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eye Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Migrane	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Immune Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug Allergy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Any Ailment not covered	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Specify _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Geographic History

List your past several residences <i>City and State only</i>	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