ALLERGY & ASTHMA FAMILY CARE, P.C.

Patient Name:_____DATE OF BIRTH:_____Date:_____

Dear Patient: We want your experience at Allergy & Asthma Family Care to be a thorough and positive one. Please complete this form to the best of your ability and state any questions or concerns that you might have for your physician. Thank you very much for choosing us.

Primary Care Physician Name:_____Phone#_____Fax:_____

1. Please describe why you are coming for this medical visit?_____
_____
_____
_____

2. Describe if anyone in your immediate family have any medical problems that your doctor should know about?_____

3A. Do you smoke? Y_____ N_____ How long?_____ How much?_____ Are you an ex-smoker? Y_____ N_____ When did you quit?_____

3B. Do you drink?_____ If Yes, how much?_____

4. Are you around pets? Y____ N_____ Which kind?_____

5A. Do you have any allergies to foods that you know of? Yes____ No_____ If Yes, what type?
_____

5 B. If you have food allergies what is the worst reaction you have ever had?_____

6. Do you have any allergies to medications that you know of? Yes_____No____If Yes, what type?
_____

7. Please check if you have any in your house/apt? ___Carpets ___Cockroaches ___Mouse ____Feathers(i.e. pillows) ___Dust ___Smoke exposure

8. What is your occupation?_____ Do you work inside or outside?_____

9. Please list any major past or current illnesses or surgeries? _____
_____

10. Please list any medications you take regularly?_____
_____

REVIEW OF SYSTEMS: (Check all that apply)

EARS: **O** itchiness **O** discharge **O** hearing loss **O** surgery **O** other_____

NOSE: **O** stuffiness **O** dripping **O** bleeding **O** post nasal drip **O** other_____

EYE: **O** itchy **O** watery **O** red **O** swelling **O** other_____

THROAT: **O** soreness **O** cough **O** throat clearing **O** bad breath **O** other_____

HEAD: **O** pressure **O** congestion **O** headache **O** sinus pain/pressure **O** other_____

LUNGS: **O** difficulty breathing **O** wheezing **O** cough **O** other_____

SKIN: O eczema O itching O hives O other _____