Family Allergy Center Patient Intake Form

Name: DOB:

Past Medical History (conditions that you currently have and are being treated for, or conditions that you have been treated for in the past). Examples would be high blood pressure, diabetes, anxiety/depression, arthritis, sleep apnea, cancer etc.

Past Surgical History: Such as tonsillectomy, sinus surgery, appendectomy, heart stent, etc

Family Medical History: are there diseases that run in your family?

Social History:

Do you use tobacco? Y / N If Yes then what type?_____
How much did you use and for how many years? _____ Quit when?_____
Do you use recreational drugs? Y / N Details_____
Occupation? _____

Medications that you take	**Dose**	**Disease it is treating**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If more space is needed please attach a list or bring to your appointment

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Name: DOB:

Do you Snore YES / NO

Do you have any allergies to any medications? YES / NO
If YES, then please list the medication and the reaction.

Medication	Reaction
_____	_____
_____	_____
_____	_____

Do you have any environmental allergies? YES / NO
If YES, then please list below.

_____

Review of Systems (Circle or write in symptoms that you have)

Constitutional- fatigue, wt loss/gain, fever, other _____ /	NONE
Eyes- double vision, blurry vision, eye pain, other _____ /	NONE
ENT- congestion, runny nose, sinus pain, other _____ /	NONE
Skin- itchy rash, dry skin, hives, other _____ /	NONE
Lungs- cough, wheezing, mucous, other _____ /	NONE
Heart- Chest pain, SOB, swelling in legs, other _____ /	NONE
GI- Nausea, diarrhea, heartburn, other _____ /	NONE
Neurologic- Headaches, memory problems, other _____ /	NONE
Immune- frequent infection, suppressed, other _____ /	NONE
Psychiatric- anxiety, depression, bipolar, other _____ /	NONE

What are you being seen for at Family Allergy Center?

Reviewed by provider _____