ALLERGY PARTNERS of Charlottesville

New Patient Information

Date_____

Name_____Sex ☐M ☐F Primary doctor_____

Birth date_____Age_____ Referring doctor_____

Briefly describe the main problem _____

_____

How bad is it [describe or rate **1** (mild) to **5** (severe)]_____

When did it start?_____

When does it happen or flare up?_____

What makes it *worse*?_____

What makes it *better*?_____

Do you notice symptoms more in the ☐ all year ☐ spring ☐ summer ☐ fall ☐ winter

If food allergies, list foods & briefly describe what type of reaction: _____

_____

Bee sting allergy? ☐ yes ☐ no. When?____.What kind? (circle) swelling, hives, trouble breathing, throat, faint/dizzy

Please check or list your past or current medical conditions or illnesses. Circle the problems you have now.

☐ allergies	☐ many ear infections	☐ immune deficiency	☐ diabetes	☐ cancer	☐ _____
☐ asthma	☐ nose/sinus polyps	☐ bee sting allergies	☐ kidney problems	☐ celiac disease	☐ _____
☐ coughing	☐ food allergies	☐ tuberculosis	☐ glaucoma	☐ snoring	☐ _____
☐ sinus problems	☐ eczema	☐ heartburn/reflux	☐ prostate problems	☐ ulcerative colitis	☐ _____
☐ pneumonia	☐ hives	☐ heart disease	☐ arthritis	☐ Crohn's disease	☐ _____
☐ bronchitis	☐ rashes	☐ high blood pressure	☐ thyroid problems	☐ alcohol abuse	☐ _____
☐ emphysema	☐ latex allergy	☐ stroke	☐ migraine headache	☐ hepatitis	☐ _____

List any surgeries or hospitalizations and the year.

_____

_____

_____

_____

_____

_____

Family History

		Mom	Dad	Sibling	Other
Asthma		❍	❍	❍	❍
Allergies		❍	❍	❍	❍
Eczema		❍	❍	❍	❍
Food allergies		❍	❍	❍	❍
Immune deficiency		❍	❍	❍	❍
Cystic fibrosis		❍	❍	❍	❍
Bee allergy		❍	❍	❍	❍

Social History

Flu shot this year? ☐ yes ☐ no **Year of last pneumonia shot**_____

Patient's job or name of school & grade _____.

Marriage status ☐ Single ☐ Divorced/Separated ☐ Married ☐ Widower

Does (☐ patient or ☐ parent) smoke or use tobacco? ☐ yes ☐ no ☐ quit ____ years ago.

Current / past cigarette smokers: How many packs a day_____? Any other cigarette smokers at home? ☐ yes ☐ no

Alcohol intake: ☐never ☐rarely ☐weekly ☐daily ☐socially. How many ☐coffee ☐tea ☐soft drinks / day?____

Pediatric Patients Only	YES	NO	Notes
Premature?	❍	❍	How many weeks early?
C-section delivery?	❍	❍	
Prolonged hospital stay after being born?	❍	❍	How long in hospital?
Breast fed?	❍	❍	
Feeding difficulties or formula changes?	❍	❍	
Poor growth and development?	❍	❍	
Immunizations late or not done?	❍	❍	
Bad reactions to vaccinations?	❍	❍	
Severe infections?	❍	❍	
Any brothers or sisters?	❍	❍	How many?

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Name:_____ Date of Visit_____

Environmental History

Housing	Foundation	Air Conditioning	Heating
☐ house	☐ basement	☐ none	☐ NONE
☐ apartment/condo	☐ crawl space	☐ window units	☐ wood stove
☐ mobile home	☐ concrete slab	☐ central air	☐ central hot air
			☐ kerosene
			☐ radiator
			☐ electric baseboard

Indoor Mold	Water Damage	Pests	Smoke Exposure
☐ NONE	☐ NONE	☐ NONE	☐ NONE
☐ AC vents	☐ leaky roof	☐ roaches	☐ parents
☐ bathroom	☐ plumbing problems	☐ rodents	☐ spouse/partner
☐ window frames	☐ musty odors		☐ grandparent
☐ walls	☐ condensation		☐ caretaker
☐ basement	☐ water stains		☐ other

Bedroom	Bed	Pets	Outdoor Environment
☐ carpet	☐ crib mattress	☐ NONE	☐ cattle
☐ ceiling fan	☐ standard mattress	☐ dogs	☐ chickens
☐ humidifier	☐ water bed	☐ cats	☐ horses
☐ sleeps in own bed	☐ down pillow/ comforter	☐ birds	☐ goats
☐ shares bed	☐ dust ruffle	☐ hamsters	☐ farm
☐ stuffed toys	☐ stuffed toys	☐ gerbils	
	☐ wool blanket	☐ rabbits	
	☐ allergy pillow cover	☐ guinea pigs	
	☐ allergy mattress cover	☐ other	
	☐ pets sleeps in bed		

How many…
Dogs inside: _____
Dogs outside: _____
Cats inside: _____
Cats outside: _____

_____

_____

_____

_____

_____

_____

_____

_____

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Name:_____ Date of Visit_____

Review of Systems: Please mark any ongoing problems for the patient.

GENERAL
- ☐ **No problems**
- ☐ poor growth
- ☐ fever
- ☐ chills
- ☐ night sweats
- ☐ poor appetite
- ☐ fatigue
- ☐ general discomfort
- ☐ weight loss

EYES
- ☐ **No problems**
- ☐ blurring
- ☐ discharge
- ☐ eye pain
- ☐ itchy
- ☐ red
- ☐ vision loss
- ☐ watery

EARS
- ☐ **No problems**
- ☐ earache
- ☐ ear discharge
- ☐ ringing
- ☐ poor hearing
- ☐ ears popping or stopped up
- ☐ world spinning / vertigo

NOSE/SINUSES
- ☐ **No problems**
- ☐ congestion
- ☐ runny nose
- ☐ postnasal drip
- ☐ nose bleeds

THROAT
- ☐ **No problems**
- ☐ hoarseness
- ☐ hard to swallow
- ☐ sore throat
- ☐ oral ulcers
- ☐ throat clearing

HEART
- ☐ **No problems**
- ☐ chest pains
- ☐ palpitations
- ☐ passing out
- ☐ foot/leg swelling
- ☐ Short of breath on lying down

RESPIRATORY
- ☐ **No problems**
- ☐ cough
- ☐ chest tightness
- ☐ coughing up blood
- ☐ daytime sleepiness
- ☐ shortness of breath
- ☐ snoring
- ☐ wheezing

GASTROINTESTINAL
- ☐ **No problems**
- ☐ heartburn
- ☐ nausea
- ☐ vomiting
- ☐ diarrhea
- ☐ constipation
- ☐ stomach pain
- ☐ blood in stools
- ☐ jaundice

JOINTS
- ☐ **No problems**
- ☐ back pain
- ☐ joint pain
- ☐ joint swelling
- ☐ joint stiffness

SKIN
- ☐ **No problems**
- ☐ swelling of skin
- ☐ dryness
- ☐ hives
- ☐ itching
- ☐ rash

NEUROLOGIC
- ☐ **No problems**
- ☐ headaches
- ☐ muscle weakness
- ☐ seizures
- ☐ passing out
- ☐ dizziness

MENTAL HEALTH
- ☐ **No problems**
- ☐ depression
- ☐ anxiety
- ☐ hyperactivity
- ☐ behavior issues

ALLERGIES/IMMUNITY
- ☐ **No problems**
- ☐ Recurring infections
- ☐ bee sting reactions
- ☐ latex reactions
- ☐ food allergies

Medications: Please list all current medications, the dose, and how often you take them.

Please include inhalers, nose sprays, prescription skin medications, and herbal supplements.

Medication/supplement	Strength	Times a day		Medication/supplement	Strength	Times a day

Drug Allergies. Please list name of drug and what type of reaction you've had.

_____ _____

_____ _____

_____ _____

_____ _____

Preferred pharmacy. List name and address (city and street/part of town).

_____