OCEAN ALLERGY

ALLERGY, ASTHMA AND CLINICAL IMMUNOLOGY

INITIAL VISIT QUESTIONNAIRE

Please answer all questions in their entirety. This is part of the medical history and is therefore confidential.

Name _____ Gender male/ female Birthdate _____

Referring Physician: _____ Tele # _____

Please list the major reason(s) for your visit: _____

PHARMACY NAME AND TELEPHONE NUMBER_____

If appropriate, please circle the months the symptoms are most prominent:

Jan Feb March April May June July Aug Sept Oct Nov Dec

PREVIOUS ALLERGY EVALUATION (indicate when and where) _____

TRIGGERS: PLEASE CIRCLE ALL THAT APPLY

DUST	FEATHERS	DOG	CAT	MOLD	FOODS	DRUGS	HUMIDITY	COLD TEMPS
STRONG ODORS	FRAGRANCE	TEMPERATURE CHANGES	WORKPLACE	HOME	FALL	SPRING		

PLEASE LIST ALL OF YOUR MEDICAL CONDITIONS PLEASE LIST ALL OF YOUR SURGERIES

FAMILY HISTORY: (please indicate which family members have allergy/immunology diseases

	MOTHER	FATHER	SIBLINGS	OTHER FAMILY MEMBERS
ENVIRONMENTAL ALLERGIES				
FOOD ALLERGIES				
ECZEMA				
ASTHMA				
RECURRENT INFECTIONS				
IMMUNE DEFICIENCY				

PLEASE LIST ALL DRUG ALLERGIES: _____ _____ _____ _____ _____

PLEASE LIST ALL FOOD ALLERGIES: _____ _____ _____ _____ _____

PLEASE LIST ALL MEDICATIONS/SUPPLEMENTS YOU ARE TAKING WITH DOSAGE AND FREQUENCY

MEDICATION	DOSAGE	FREQUENCY	MEDICATION	DOSAGE	FREQUENCY

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SOCIAL HISTORY: (CIRCLE ALL THAT APPLY) **NAME: _____**

SMOKING STATUS:	CURRENT SMOKER	FORMER SMOKER	NEVER SMOKER

HAVE YOU SMOKED MORE THAN 100 CIGARETTES IN A LIFETIME?	YES	NO
DO YOU USE A SMOKELESS TOBACCO PRODUCT?	YES	NO
ARE YOU AT RISK FOR SECOND HAND SMOKE?	YES	NO

CURRENT OCCUPATION _____FORMER OCCUPATION _____

HAVE YOU HAD ANY OCCUPATION WITH ALLERGIC OR TOXIC EXPOSURE? _____

IF YES WHEN AND WHAT WAS THE EXPOSURE? _____

ENVIRONMENTAL HISTORY: (FOR PATIENTS WITH ASTHMA, NASAL ALLERGIES, OR SINUS DISEASE CIRCLE WHERE APPROPRIATE)

HOME:	HOUSE	APARTMENT	CONDO	MOLD/WATER DAMAGE
RUGS:	WALL TO WALL	AREA		
HEATING SYSTEM:	RADIATOR	HOT WATER BASEBOARD	FORCED HOT AIR	OTHER
BEDROOM:	SHARED	SINGLE		
ALLERGY PROOF COVER	PILLOWS	MATTRESS	BOX SPRING	
PETS:	CATS	DOG	OTHER	

REVIEW OF SYSTEMS: (please circle all that apply)

CONSTITUTIONAL:	LOSS OF APPETITE	FEVER	NIGHT SWEATS	RECENT FATIGUE	SYSTEMIC ILLNESS	RECENT WEIGHT GAIN/LOSS
HEAD:	HEAD TRAUMA	HEADACHE				
EYES:	BLURRED VISION	VISUAL CHANGES	ITCHING/TEARING	REDNESS	LIGHT SENSITIVITY	PAIN
ENT:	HEARING LOSS	BLOODY NOSE	SINUS CONGESTION	DIFFICULTY SWALLOWING		
RESIRATORY:	COUGHING BLOOD	WHEEZING	COUGHING	SPUTUM PRODUCTION	SHORTNESS OF BREATH	
CARDIOVASCULAR:	CHEST PAIN	RAPID OR IRREGULAR HEARTBEAT	DIFFICULTY BREATHING WHEN LYING DOWN	SHORTNESS OF BREATH AWAKENING FROM SLEEP	LOWER EXTREMITY SWELLING	
GASTROINTESTINAL:	NAUSEA	VOMITING	ABDOMINAL PAIN	CHANGE IN BOWEL HABITS		
SKIN:	RASHES	SKIN ULCERS	HIVES	ITCHINESS		
NEUROLOGICAL:	DIZZINESS	HEADACHE	SYNCOPE	WEAKNESS		
ENDOCRINE:	HYPO-GLYCEMIA	EXCESSIVE THIRST	EXCESSIVE URINATION			
HEMATOLOGIC/LYMPHATIC:	EASY BRUISING	BLEEDING	CLOTTING DISORDER	CALF PAIN		
ALLERGY/IMMUNOLOGY:	SEASONAL ALLERGIES	FOOD ALLERGIES	DRUG ALLERGIES			
GENERALIZED PAIN:	YES	NO				