THE ALLERGY & ASTHMA GROUP

______________________	______________________	______________________
Referring Physician	Pharmacy	Pharmacy #

Patient's Name: ____ Age: ____________________

Date: ______________________________

Chief Complaints: (check the main symptoms)

Head or nose symptoms	**Chest symptoms**	**Skin symptoms**	**GI**
_____Sneezing	_____Coughing	_____Hives	_____Acid reflux
_____Nose bleeding	_____Wheezing	_____Eczema	_____Throat clearing
_____Runny nose	_____Shortness of breath	_____Itching	_____Heartburn
_____Postnasal drainage	_____Chest infection	_____Other	_____Acid taste in mouth
_____Sinus infection	_____Hoarseness		
_____Sore throat			
_____Ear blocking		Describe: ______________________________	
_____Headache		______________________________	
_____Eye symptoms		______________________________	

Age when symptoms started: Head or nose symptoms ____________ Chest symptoms ____________

Skin symptoms __________________ GI symptoms ______________

Indicate the pattern of symptoms:

	Head/Nose	Chest	Skin
Year round, no seasonal variation			
Year round, worse seasonally			
Seasonal only			

If seasonal, list months ____

Allergic to any drugs?

Yes No If so list drugs:____

List medicine used for allergy/asthma: ____

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Have there ever been allergic symptoms from the sting of a bee, wasp, yellow jacket, or hornet, other than local swelling at the site of the sting (symptoms such as generalized itching, hives, swelling in areas remote from the sting, hay fever, asthma, nausea, vomiting, etc.)? Yes No

Has there been skin testing for allergy previously? Yes No

If so, give name and location of doctor doing the testing: ____

Have "allergy shots" been used previously? Yes No

If so, for how long? ____

Are there pets in home? Yes No If so, what kind? ____________________________________

Kept outside completely ____ Outside some, inside some _____ Inside most of time ____

Are there increased symptoms from any of the following?

a. Allergens		**b. Irritants**	
_____Mowed grass	_____House dust	_____Smoke	
_____Dead grass	_____Cats	_____Perfumes	_____Paints
_____Dead leaves	_____Dogs	_____Soaps	_____Hair spray
_____Hay	_____Feathers	_____Detergent	_____Outside dust

c. Weather Changes

_____Windy days

_____Temperature/weather change

d. Foods (list):

____

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Indicate anything else you have noted that increases symptoms ________________________________

List any medication (including over-the-counter drugs, creams, suppositories, etc.) taken with any regularity:

____

____

REVIEW OF SYSTEMS

Please check if you have/had problems related to the areas indicated.

	YES	NO
1. CONSTITUTIONAL		
Weight change		
Fevers		
Sweats		
Fatigue		
2. EYES		
Glaucoma		
Cataracts		
Vision surgery		
3. EARS, NOSE, THROAT		
Loss of hearing		
Dizziness		
Hay fever		
Nose bleeding		
Gum bleeding		
4. RESPIRATORY		
Chronic cough		
Bronchitis		
Shortness of breath		
Asthma		
Pneumonia		
5. CARDIOVASCULAR		
Heart attack		
Chest pain/angina		
Heart murmur		
Anemia		
Transfusions		
Phlebitis or blood clots		
Rheumatic fever		
6. GASTROINTESTINAL		
Acid reflux		
Blood in stools		
Diarrhea		
Constipation		
Gall bladder disease		

	YES	NO
7. ENDOCRINE SYSTEM		
Diabetes		
Thyroid problem		
Hormone treatment		
8. BREAST/GENITAL		
Menopause		
Masses		
Genital infections		
9. URINARY SYSTEM		
Urinary tract/bladder infections		
Kidney stones		
Incontinence		
Trouble urinating		
Prostate problems		
10. SKIN		
Cancers		
Rashes		
11. NEUROLOGIC		
Stroke		
Seizures		
Head injury		
Nerve damage		
12. PSYCHIATRIC		
Depression		
Anxiety		
13. MUSCULOSKELETAL		
Osteoarthritis		
Rheumatoid arthritis		
Gout		
14. HEMATOLOGIC		
Anemia		
Enlarged lymph nodes		
Easy bleeding		

OTHER: ___________________________________

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The information provided in this form is true and complete to the best of my knowledge.

Patient signature ____

Updated (date) ______________ Form reviewed by physician: ___________________________ (Initials)