ADVANCEMENTS IN ALLERGY AND ASTHMA CARE, LTD.

«PatientFullName» DOB: «PatientDOB»
Chart#: «PatientChartNumber»

Reason for visit: _____Referred by: _____

Allergies to Medications: _____

Pharmacy: _____ Location: _____ Phone: _____

Have you ever had surgery or an overnight hospitalization

_____Date _____

_____Date _____

_____Date _____

Any other medical conditions/diagnoses (i.e. high blood pressure, heart problems, diabetes, etc.)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Prescription and over the counter medications including dose (or bring your prescription bottles with you)

_____ _____ _____

_____ _____ _____

_____ _____ _____

Family Social History	Please Circle or Describe			
Does your mother have	allergy	asthma	chronic sinusitis	N/A
Does your father have	allergy	asthma	chronic sinusitis	N/A
How many siblings do you have				
How many of your siblings have	( ) allergy	( ) asthma	( ) chronic sinusitis	
Adult social history				
What is your occupation				
Are you	single	married	divorced	other
Number of children				
Child Social History (only for patients under age 18)				
Education level				
Child custody status				
Child lives with				
Other Social History				
Living arrangements	single family home	apartment	other	
What is your house heating source	forced air	water	wood	

	Yes	No	
Are you exposed to mold			
Have you lived in another part of the US/world in the past 5 years			If yes, where
Do you have any contact with animals/pets (home or daycare)			If yes, please list
Any feather/down comforter, pillow or jacket			
Is your diet normal			
Any caffeine use			If yes, how much
Any alcohol use			If yes, how much
Do you take any vitamin D			If yes, how much

Smoking History	Yes	No
Are you exposed to smoke/vape		
Current tobacco/marijuana use or vaping		
Former tobacco/marijuana use or vaping		

If yes, how much? _____
For _____ years

If you quit, when

Any other types of tobacco use:

Cigars Chew Pipe

Immunizations

Date of most recent flu vaccine:

Date of Pneumovax:

Date of Prevnar 7, Prevnar 13 or Prevnar 20:

Date of Tdap (tetanus with whooping cough):

Imaging	Yes	No
Have you ever had sinus x-ray or CT scan If yes, please list test name and date		
Have you ever had chest x-ray or CT scan If yes, please list test name and date		

Please bring to appointment:

Recent RAST test results

Recent Allergy Skin Test results