Dr. Mark Stahl, D.O.
Diplomate, American Board of Allergy & Immunology

14615 San Pedro Ave, Ste. 250 Phone: 210-490-2051
San Antonio, TX 78232 Fax: 210-490-6758

New Patient Health History

Patient Name _____ Date of Birth:_____

Primary Dr: _____ Practice Type: ☐ General ☐ Family ☐ Internist ☐ Peds

Referred by: _____ ☐ Self-referred ☐ Primary Doctor

Reason for visit:

☐ nose symptoms	☐ sinus symptoms	☐ cough	☐ trouble breathing
☐ asthma/wheezing	☐ hives/swelling	☐ rash/eczema	☐ food reactions
☐ drug allergy	☐ insect sting allergy	☐ recurring infections	☐ other _____

Patient's symptoms (check all that apply):

☐ fever ☐ chills ☐ fatigue

Nose

☐ stuffy nose	☐ runny nose	☐ sneezing	☐ itchy nose
☐ frequent sniffling	☐ loss of smell	☐ loss of taste	☐ nose bleeds
☐ mouth breathing	☐ loud snoring	☐ sinus pain	☐ nasal polyps

Eyes

☐ itchy eyes	☐ watery eyes	☐ red eyes	☐ puffy eyelids
☐ eye drainage	☐ dryness/burning	☐ blurred vision	

Ears

☐ itchy ears	☐ stuffiness/popping	☐ hearing loss	☐ earache

Throat and mouth

☐ itchy throat/palate	☐ sore throat	☐ hoarseness	☐ throat clearing

Head

☐ sinus headaches	☐ migraine headaches	☐ dizziness

Chest

☐ nighttime cough	☐ daytime cough	☐ coughing up mucus	☐ wheezing
☐ short of breath	☐ pain/tightness	☐ symptoms with exercise	

Stomach

☐ nausea	☐ vomiting	☐ diarrhea	☐ constipation
☐ heartburn	☐ pain/cramping		

Skin

☐ hives	☐ itchy skin	☐ skin rash	☐ swelling

Other

☐ poor sleep	☐ body aches	☐ arthritis	☐ other_____

Immunology History: (please check all that apply)

☐ recurrent **sinus** infections	☐ recurrent **ear** infections	☐ recurrent **throat** infections
☐ recurrent **pneumonia**	☐ recurrent **bronchitis**	☐ recurrent **skin** infections

When did these **symptoms initially occur** (age or date)?_____

Symptoms are **worse** (check all that apply):

☐ All Year	☐ Spring	☐ Summer	☐ Fall	☐ Winter	
☐ Morning	☐ Afternoon	☐ Evening	☐ Night	☐ Indoors	☐ Outdoors

What triggers nose, eye, ear, head, skin, swelling, stomach or other symptoms?

☐ colds	☐ exercise	☐ smoke	☐ dusty areas
☐ dog	☐ cat	☐ strong odors	☐ perfume
☐ weather changes	☐ dampness/rain	☐ air conditioning	☐ foods
☐ molds	☐ grass	☐ weeds	☐ trees
☐ flowers	☐ smog	☐ menstruation	☐ strong emotions
☐ cosmetics	☐ soaps	☐ fabrics	☐ paint/varnish

Please describe any significant reactions to <u>insect stings</u>: _____

Please list any reactions to <u>foods</u>: _____

Please describe any significant reactions to <u>latex</u>: _____

If patient has asthma, wheezing, or shortness of breath: ☐ Yes (see below) ☐ No, not applicable

Age at onset: _____ # of hospitalizations: _____ ICU admissions: _____

In the past 12 months how many:

Doctor/Urgent Care/ER visits?:_____ Missed school/work days?:_____ Oral steroid courses?:_____

Do chest symptoms awaken the patient at night? ☐ Yes ☐No

Is the patient's activity, including exercise, restricted due to chest symptoms? ☐ Yes ☐No

When are the patient's chest symptoms at their worst? (circle)

Year round Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec

Previous allergy or immunology testing? ☐ Yes ☐No If yes, please describe: _____

_____

By Dr: _____ Year: _____

Previously/currently on allergy shots? ☐Yes ☐No If yes: For _____years Shots helped? ☐ Yes ☐No

Current Medications: _____

_____

What medicines has the patient been on in the past? (please circle all that apply)

☐ antihistamines? Zyrtec (cetirizine), Xyzal, Claritin (loratadine), Clarinex, Allegra (fexofenadine)
☐ nasal steroids? Flonase, Nasonex, Rhinocort, Nasocort, Veramyst, Omnaris
☐ nasal antihistamines? Astelin, Astepro, Patanase
☐ other? Singulair, Dymista

Any medication allergies? ☐ None ☐ Yes, allergic to: _____

Please list current or past significant health conditions: _____

_____

_____

Surgical history (with age at time of procedure)**:** _____

_____

_____

Family history (check all that apply):

☐ Allergies ☐ Asthma ☐ Eczema ☐ Food allergy ☐ Bee sting allergy ☐ Cystic fibrosis
☐ Nasal polyps ☐ Immune deficiency/disorder ☐ Other chronic illness: _____

Please provide information about the patient and their family:

Housing	☐ house	☐ apartment	☐ mobile home	
Flooring:	☐ carpet	☐ tile	☐ wood	☐ vinyl
Exposures:	☐ strong fumes	☐ pollution	☐ fireplace	☐ wood-burning stove
Air conditioning:	☐ central	☐ window	☐ no air conditioning	

Pets: ☐ Cats (____#) inside/outside ☐ Dogs (____#) inside/outside ☐ Other Pets: _____

Smoking inside/outside the home: ☐ Yes (see below) ☐No

☐ Self (patient) ☐ Mother ☐ Father ☐Other(s) _____

How long has the patient lived in Texas? _____ **Previous location(s)**: _____

Who lives in the home with the patient? _____

All pages reviewed by provider: _____ ***Date*** _____