PLEASE USE **BLUE OR BLACK** INK

DENNIS H. KIM, M.D.
STEPHEN J. KORNFELD, M.D., FAAAAI, FACAAI

Diplomate of American Board of Allergy and Immunology-Adult and Pediatric

Name_____ Date of Appointment_____Age_____Sex_____

Country of Birth_____ Years in USA_____ Marital Status: M S W D Birthdate_____

Primary Care Doctor_____Phone_____

Address of Doctor_____

Other Doctors You See on a Regular Basis_____

_____

Referred by_____

Years in Florida_____ Previous Residence_____

This visit is arranged to discuss the following problems (chief complaint):

1)_____2)_____

3)_____4)_____

When and where was the first time the problem occurred?_____

_____

Describe your first attack and typical

attack_____

_____

When did you last have an attack?

_____ How often do they occur?

_____ What medications have

you tried to help with the problem and how did they work?_____

_____

~~Turn to page 2.~~

OFFICE USE ONLY:

Is your illness increasing in frequency? Yes___ No___ Severity? Yes____ No_____

Patient: Please fill in the blanks and circle all symptoms that apply:

Nasal Symptoms: Y N
Age at Onset_____
Season_____
Congestion
Sneezing
Nasal Itching
Throat Itching
Discharge
Bad Breath
Post-Nasal Drip
Upper Jaw Pain
Ear Pressure
Sinus Infections (#___per year)

Eye Symptoms: Y N
Age at Onset_____
Season_____
Watery
Redness
Swelling
Itching
Burning

Indigestion: Y N
Upset Stomach
Heartburn
Ulcer Disease

Chest Symptoms: Y N
Age at Onset_____
Season_____
Cough
Shortness of Breath
Tightness
Wheeze
Worsened by:
(Colds, night, exercise)

Rash: Y N
Age at Onset____
Season
Itching
Location____

Sleep Disturbance: Y N
Daytime Fatigue
Mouth breathing
Snoring
Difficulty falling asleep
Difficulty staying asleep
Sleep feels inadequate

Headaches: Y N
Age at Onset_____
Season_____
Location_____
Pain Type_____
(ie. Pressure, Sharp)
Frequency_____/week
Assoc. Symptoms:
Eye (Aura)
Nasal Congestion
Nausea
Vomiting

Do your allergy symptoms increase on exposure to:

Dust	**Y N**	Other Pets	**Y N**	Cold Air	**Y N**	Emotion (Stress)	**Y N**
Mold	**Y N**	Odors	**Y N**	Weather Changes	**Y N**	Air Conditioning	**Y N**
Dogs	**Y N**	Sprays	**Y N**	Outside	**Y N**		
Cats	**Y N**	Smoke	**Y N**	Inside	**Y N**		

Home Environment (Please fill in the blanks OR circle Yes or No.)

Home age_____ Carpet **Y N** A/C Central **Y N** Tobacco Smoke: **Y N** Start_____ Stop_____
Pillow(Feather, Synthetic) Indoor Plants#_____ Dust Covers **Y N** # Cigarettes/day _____
Pets(#): Dog_____Cat_____Bird____Other_____ Air Filters **Y N** Does anyone else smoke in your house?_____
Alcohol Use: **Y N** Drinks per week? _____

When was your last X-ray and results?

Chest X-ray: Y N _____ **Sinus X-ray: Y N** _____

List all current medications, doses, and frequencies of use, including over the counter medications:

1._____ 5._____ 9._____
2._____ 6._____ 10._____
3._____ 7._____ 11._____
4._____ 8._____ 12._____

What medications for allergies have you used? Nasal sprays **Y N** If yes, list: _____

Antihistamines: **Y N** If yes, list: _____ Singulair: Y N

Job and Occupational environment: _____

Absenteeism due to allergies_____

Hobbies: _____

Do you have any food allergies? Y N (List with type of reaction) _____

_____

_____

Do you have any drug allergies? Y N (List with type of reaction)_____

_____

Do you have any skin allergies? Plants: Y N_____ **Cosmetics: Y N**_____ _____

Metals: Y N_____ **Other:** _ _____

Do you have any stinging insect allergies? Y N _____

Name_____

Family History Father_____

Of Allergies: Mother_____

Siblings_____

Children_____

Have you ever had: Diabetes: Y N _____ **Thyroid Disease: Y N** _____

Pneumonia: Y N _____**TB: Y N** _____ **High Blood Pressure: Y N** _____

Heart Disease: Y N _____ **Heart Murmur: Y N** _____ **High Cholesterol: Y N** _____

Ulcer Disease: Y N _____**Indigestion: Y N** _____ **Hepatitis: Y N** _____

Blood Transfusion: Y N _____**Nausea, Vomiting, Diarrhea: Y N** **Broken Nose: Y N** _____

Eye Disease: Y N _____**Wear Contact Lenses: Y N**_____ **Glaucoma: Y N** _____

Surgery: _____

_____

Hospitalizations: _____

Other Medical Conditions: _____

Have you ever been treated for anxiety or depression? Y N Describe:_____

STOP HERE:

DO NOT FILL OUT BELOW:

PEFR: _____(_____) B.P._____P._____R.R._____T._____HGT._____WT_____

P.E.: Gen App: Nl WDWN M F NAD Obese **BMI: ____ (circle one) NORMAL HIGH LOW**

EARS: Nl T.M.: Erythema Scarred Lt. Reflex Aud Canal (R) (L) EYES: Nl Lid Conj. Shiners PERRLA

NOSE: Nl Mucosa: pale erythematous Trans/exudates Turbinates: enlarged Septum: deviated Crease

MOUTH: Nl Lips Mucosa Teeth Gums Palate: hard soft: Tongue:
Post. Pharynx: erythema PND cobblestoning exudates Tonsils

NECK: Nl symmetry masses thyroid trachea midline

NODES: Nl neck other

CHEST: Nl inspection SSNR cl A&P wheezing rhonchi rales

CVS: Nl RR m g

ABD: Nl BS + H K S masses tenderness

EXT: Nl C C E SKIN: Nl rash lesions dermato

OTHER:

Medical Decision-Making: □ Case discussed w HCW

ACE Inh Anx/Dep Arrhythmia β Blocker BPH CAD Coumadin D.M. Glau HBP Hep Dis
Obesity Osteoporosis Renal Dis Seizure Sl Apnea Thyroid Med All

Imp: 1. _____

2. _____

3. _____

4. _____

Name_____