Advanced **A**llergy &
Asthma **C**are of WNY, P.C.
Adult & Pediatric Allergy

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Patient History Form

For patient safety, PLEASE do not wear perfumes/colognes. Do not bring food to the office.
PLEASE refrain from smoking prior to your visit.
PLEASE read carefully and complete this questionnaire. Please print answers legibly in black ink.

First Name: _____ Last Name: _____ DOB: _____
Male □ Female □ Married □ Single □ How long have you lived in WNY? _____
If under 18 years old, name of parent here today? _____
Are any of your family members patients with us? Names: _____
Name of patient's current Primary Care Provider ? _____
Who referred you to us? _____

Reason for your visit today

☐ Allergies ☐ Seasonal ☐ All Year ☐ Asthma ☐ Cough ☐ Sinusitis ☐ Recurrent Infections
(please bring any available pictures) □ Hives ☐ Rash ☐ Eczema ☐ Food Allergy ☐ Insect Allergy ☐ Drug Allergy
□ Eye Allergy □ Other _____

Pharmacy Information - Name:_____Phone #: _____
Drugs Tried in the Past:

Allergies (Please list all drug and food allergies both prescription and over the counter)

Drug and Reaction	Food and Reaction

Please list all current medications and supplements (Bring with you)

Do you have a latex allergy? N / Y **Do you where a Medic Alert bracelet?** N / Y Current / Expired
Do you have an insect allergy? N / Y to what? _____ **Do you carry an Epi-Pen/AuviQ?** N / Y

Previous Allergy Testing? N / Y Physician _____ When _____
Allergy Shots? N / Y How long _____ years **Date of last Chest X-Ray _____** Facility (where) _____

Last PPD (Test for Tuberculosis) _____Date of last Sinus X-Ray/CAT Scan_____ Date of Pneumovax_____Flu shot _____
Immunizations up to date? N / Y Missing: _____
Previous Pulmonary Evaluation N / Y Who _____
Previous ENT (Otolaryngologist) Evaluation N / Y Who _____

Please check all current symptoms

☐ Sneezing ☐ Watery eyes ☐ Runny nose ☐ Blocked Nose ☐ Itching of the nose ☐ Itching of the eyes ☐ Itching of the ears
☐ Itching of the mouth ☐ Shortness of breath ☐ Coughing ☐ Wheezing ☐ Sputum, Color? _____
☐ Swelling of the lips ☐ Swelling of the body ☐ Rash ☐ Headache ☐ Fatigue ☐ Nausea ☐ Diarrhea ☐ Stomach cramps
When did these symptoms first occur? _____ How often & when do the symptoms occur? _____
How severe are they on a scale of 1 - 10? _____ How long do they last? _____

DO YOU HAVE ASTHMA OR A HISTORY ASTHMA? Y/N Age onset___ Hospitalized # ____ ICU#____ER #_____
Steroids # ____ Last on Steroids _____ Albuterol use per week_____ Symptoms per week_____
Interference with activity Y / N Nighttime symptoms per mo_____

Allergy & Asthma Triggers: ☐ Aspirin Products ☐ Chemicals ☐ Colds/Flu ☐ Dust ☐ Emotion/Stress ☐ Exercise ☐ Foods ☐ Humidity ☐ Menstrual Cycle ☐ Mold ☐ Ozone ☐ Perfumes ☐ Pollen ☐ Seasons ☐ Pets _____ ☐ Sinus Infections ☐ Temp/Weather Changes ☐ Tobacco ☐ Others: _____

Questions regarding your environment

Home: □ Apartment _____Floor □ House □ Mobile Home □ Duplex Age of Home _____years
Location of Home: □ Rural Area □ Downtown Area □ Suburban Area
Living area of home: ☐ Carpet ☐ Wood ☐ Tile
Bedroom area: ☐ Draperies ☐ Blinds ☐ Shades ☐ Carpet ☐ Wood ☐ Tile
Bedding: Age of Mattress _____years ☐ foam ☐ feather ☐ memory foam
Allergy covers: □ Mattress □ Pillow □ None
Heating System: ☐ Forced hot air ☐ Hot water ☐ Steam ☐ Wood Burning stove ☐ Radiant
Air Conditioning: □ Central □ Window units □ No A/C □ Air purifier □ Air cleaner
□ Humidifier □ Dehumidifier **Electrostatic or HEPA Filter use? _____ Where?_____**
Basement: □ Wet □ Dry □ Moldy □ Mildew □ Damp □ Finished □ Not finished
Type of Pets: □ CATS, How many? ____ □ DOGS, How many? ____ □ Other_____
□ Inside □ In bedroom □ Outside
Pets exposure at: □ Friends/Family _____
Smoking: □ Current Smoker _____ PPD for_____ yrs □ Never Smoked □ Patch □ E-Cigarettes
□ QUIT smoking _____yr(s) ago Smoked from age _____ to age _____ Max amount smoked _____ PPD
Exposed to passive smoke: □ Mom □ Dad □ In own Home □ At friends home □ Work □ in Car
□ Other_____
Alcohol Consumption? □ Never □ Social □ Several times per week Time of Day/Night: _____
Other Habits? N/Y Please explain: _____
Patient's Occupation: _____ □ Retired □ Student **Spouse's Occupation:** _____ □ Retired □ Student
Parent's Occupation: Mom: _____□ Retired Dad: _____□ Retired
Patient's Hobbies: _____

Patients Past Medical History

☐ Migraines ☐ Stroke ☐ Diabetes ☐ Hypertension ☐ Heart Disease ☐ Emphysema ☐ Ulcers ☐ Liver Diseases
☐ Kidney Disease ☐ TB ☐ High Cholesterol ☐ Thyroid Disease ☐ Cancer ☐ AIDS/HIV ☐ Arthritis ☐ Lupus
☐ Immune Deficiency ☐ IBS ☐ Sleep Apnea ☐ Glaucoma ☐ Cataracts ☐ Acid Reflux ☐ Hepatitis ☐ Epilepsy
☐ Osteoporosis/Osteopenia ☐ Pneumonia ☐ Croup ☐ Bronchitis ☐ Vocal Cord Dysfunction ☐ RSV
☐ Prostate Disease ☐ Hiatal Hernia ☐ Anxiety ☐ Depression ☐ Other: _____

Family History: Please indicate relationship: grandmother=GM, grandfather= GF, mother = M, sister =S, brother = B

	Mothers Side of Family	Fathers Side of Family
Asthma		
Allergic Rhinitis		
Lupus		
Rheumatoid Arthritis		
Scleroderma		
Eczema		

Patient's Past Surgical History (Please Check Surgery and list age/year)

	Age	Year		Age	Year
☐ Tonsils			☐ Nasal Polyps		
☐ Adenoids			☐ Sinus Surgery		
☐ Ear Tubes			☐ Nasal Septum Repair		
☐ Thyroid			☐ Heart Surgery		
☐ Gallbladder			☐ Hysterectomy		
☐ Appendectomy			☐ Tubal Ligation		
☐ Back			☐ Other:		

Please Sign_____Date_____/_____/_____