(Office Only) MRN: _____

Revere Health Allergy & Immunology

Henry Yeates, MD • Tammy Jacobs, MD
Evangeline Lindorf, NP

PATIENT NAME: _____
DOB: ____/____/_____ **AGE:** _____ **SEX: M / F**
Primary Care MD: _____
Referring MD: _____
Pharmacy (Name/Location): _____

Date: _____/_____/_____
Form completed by: ☐ Patient ☐ Parent/Guardian: _____
Main Reason for Today's Visit:

Please also check if you have any of the following conditions:

☐ Allergic Rhinitis/Sinusitis (Hay Fever) ☐ Asthma or Breathing Problems ☐ Food Allergies/Reactions ☐ Eosinophilic Esophagitis
☐ Allergic Conjunctivitis (Eye Allergy) ☐ Hives or Rash ☐ Contact Dermatitis/Rash ☐ Atopic Dermatitis (Eczema)
☐ Allergy/Reaction to Stinging Insects ☐ Allergy/Reaction to Latex ☐ Penicillin Allergy ☐ Frequent Infections

Medical/Surgical/Hospitalization History:

☐ Gastroesophageal Reflux (Heart Burn) ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes
☐ Sleep Apnea ☐ Osteoporosis (or osteopenia) ☐ Thyroid Disease ☐ Cancer, please detail below

Other Diagnosis/Surgery/Hospitalization Date Medications for Medical Condition

_____
_____
_____

Current Medications (Please Include Name/Dosage/Frequency and Vitamins/Supplements/Over the Counter Medications):

_____ _____ _____
_____ _____ _____

Allergy History:

Medication Allergies Reaction (such as hives, rash, swelling, vomiting, wheezing)

_____ _____
_____ _____

Other (Food, Latex, Stinging Insects) Reaction (such as hives, rash, swelling, vomiting, wheezing)

_____ _____
_____ _____

Immunizations Up To Date: ☐ Yes ☐ No

Influenza Vaccine (this season from September to April): ☐ Yes ☐ No

If you have not received the flu shot this season, would you like it to be administered at this office visit? ☐ Yes ☐ No

Family History: ☐ Unknown ☐ Adopted

	None	Mother	Father	Sibling(s)	Grandparent(s)	Other relative, specify:
Nasal/Sinus Allergies (Seasonal Allergies/Hay Fever)	☐	☐	☐	☐	☐	_____
Asthma	☐	☐	☐	☐	☐	_____
Food Allergies	☐	☐	☐	☐	☐	_____
Atopic Dermatitis (Eczema)	☐	☐	☐	☐	☐	_____
Bee sting allergy	☐	☐	☐	☐	☐	_____
Eosinophilic Esophagitis or Trouble Swallowing	☐	☐	☐	☐	☐	_____
Urticaria or Angioedema (Hives or Swelling)	☐	☐	☐	☐	☐	_____
Autoimmune Disease (such as Thyroid Disease)	☐	☐	☐	☐	☐	_____
Immune Problems or Frequent Infections	☐	☐	☐	☐	☐	_____
Heart Disease	☐	☐	☐	☐	☐	_____
Stroke	☐	☐	☐	☐	☐	_____
Lung Disease (such as COPD)	☐	☐	☐	☐	☐	_____
Diabetes	☐	☐	☐	☐	☐	_____
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	_____
Osteoporosis	☐	☐	☐	☐	☐	_____
Cancer, Type: _____	☐	☐	☐	☐	☐	_____
Other Conditions: _____		☐	☐	☐	☐	_____
_____		☐	☐	☐	☐	_____

TURN PAGE

Social/Environmental History:

Do you smoke or are you a former smoker? ☐ Yes ☐ No If yes, __ packs per day for __ years. Quit __ years ago.
Do you drink alcohol? ☐ Yes ☐ No
Do you use any drugs/medications recreationally? ☐ Yes ☐ No
Occupation or grade in school: _____ ☐ Homemaker ☐ Unemployed
☐ No Daycare (Stays at Home) ☐ Preschool ☐ Grade School ☐ High School ☐ College
With whom do you (does your child) primarily live: _____ Multiple Households: ☐ Yes
Pets in or around the home: ☐ None ☐ Cat(s) ☐ Dog(s) ☐ Guinea Pig(s) ☐ Bird(s) ☐ Horse(s) ☐ Other: _____
Does anyone inside the home smoke? ☐ Yes ☐ No
Is there any water damage in the home? ☐ Yes ☐ No
Is there any mold inside or outside of your home? ☐ Yes ☐ No
Are there problems with pests inside the home? ☐ Yes ☐ No If yes, specify: _____
What type of heating do you have in your home? ☐ Gas/Forced air ☐ Fireplace/Gas stove ☐ Other: _____
What type of air conditioning do you have? ☐ Swamp cooler ☐ Central air ☐ Window units ☐ None
Do you have carpeting in your home? ☐ Throughout ☐ Minimal ☐ No
Do you use feather blankets or pillows? ☐ Yes ☐ No
Any strong fragrances used in your home? ☐ Yes ☐ No
Do you (does your child) follow a special diet? ☐ Yes ☐ No
If yes, please describe: _____
Have you (or your child) traveled internationally? ☐ Yes ☐ No
If yes, when/where: _____

Review of Systems:

Please indicate any symptoms you (or your child) have experienced recently.

Constitutional: ☐ Fever ☐ Chills ☐ Fatigue ☐ Loss of appetite ☐ Weight loss ☐ Weight gain
Skin: ☐ Rash ☐ Itching ☐ Hives ☐ Dryness ☐ Frequent skin infections
Head: ☐ Headache ☐ Sinus pressure ☐ Sinus tenderness
Eyes: ☐ Itchy eyes ☐ Red eyes ☐ Burning eyes ☐ Watery eyes
Ears: ☐ Itchy ears ☐ Frequent ear infections ☐ Ear tubes
Nose: ☐ Itchy nose ☐ Sneezing ☐ Runny nose ☐ Nasal congestion ☐ Frequent sinus infections
Throat: ☐ Heart burn ☐ Difficulty swallowing ☐ Feeling food getting stuck ☐ Painful swallowing
Respiratory: ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Chest tightness ☐ Frequent pneumonias
Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ History of fainting
Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea ☐ Blood in the stool ☐ Constipation ☐ Liver problems
Genitourinary: ☐ Kidney problems ☐ Kidney stones ☐ Frequent infections ☐ Incontinence
Musculoskeletal: ☐ Muscle pain ☐ Joint pain ☐ Joint swelling
Endocrine: ☐ Frequent urination ☐ Thirst ☐ Heat or cold intolerance
Neurological: ☐ Seizures ☐ Learning problems ☐ Migraines ☐ Numbness/tingling in extremities
Psychiatric: ☐ Stress ☐ Depression ☐ Anxiety ☐ Behavioral problems
Other Symptoms: Please List: _____

Review of Systems Completed: _____
Patient Signature

We are committed to providing you with the highest quality of allergy/immunology care. May we contact you for feedback?

☐ **Email** _____ ☐ **Text*** (_____) _____-_____ *standard picture text messaging rates apply