Revere Health
Allergy, Asthma & Immunology

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MRN:_____

Patient Name: _____

Age: _____ **Date of Birth**: _____ **Sex**: Male / Female **Pregnant**: Yes / No

Primary Care Dr: _____ **Referring Dr:** _____ **Pharmacy:** _____

❑ Same as Primary Care Physician

MAIN REASON for visit:

Laboratory results pertaining to this referral? **Yes / No** Doctor's office or laboratory: _____

(Please circle other concerns to be addressed at other visits)

Allergic reaction(s)	Nasal/Sinus allergies	Eye allergies	Throat clearing	Cough	Shortness of breath
Eczema	Hives / Rash	Swelling	Heartburn	Difficulty swallowing	Trouble with exercise
Food allergies	Insect allergy	Drug allergy	Vaccine reaction	Frequent infections	Asthma

Medical History **(Allergy related)** Please circle **only** physician confirmed diagnoses

Anaphylaxis	*Allergic rhinitis*	*Allergic conjunctivitis*	*Asthma*	*# Sinus infections per year _____*	
Eczema	*Atopic dermatitis*	*Urticaria*	*GERD (esophageal reflux)*	*Food allergies*	*Immunodeficiency*
Contact dermatitis	*Stinging insect allergy*	*Angioedema*	*Eosinophilic esophagitis*	*Drug allergy*	*Other:*

Have you ever seen an allergist before? **Yes / No** When? _____ Dr: _____

Did you have a skin test? **Yes / No** When? _____

What **allergy medications** have you tried? _____

For skin testing: Have you stopped all allergy/reflux-antihistamines for 7 days? **Yes / No**

*Did you receive the Influenza vaccine this season (Sept to Apr)? Yes / No

If yes, approx. date: _____

*Would you like the **flu shot** today? **Yes** / No

Hospitalizations: (List dates)	**Surgeries:** (List dates)

Medical History:	***Current Medications:***		***Medication Allergies:***
			❑ No known drug allergies

Are you on a medication to control your **high blood pressure**? **Yes / No** *If so, what is the medication?* _____

Do you have **heart disease**? **Yes / No**

Family History: (mark X or indicate detail if applies) ❑ Adopted or Unknown

	Mother	**Father**	**Siblings**	**Grandparent**
Nasal/Sinus allergies				
Asthma				
Food allergies				
Atopic Dermatitis / Eczema				
Bee/stinging insect allergy				
Eosinophilic Esophagitis (trouble swallowing)				
Immune problems / Frequent infections				
Urticaria or Angioedema (hives or swelling)				
Autoimmune disease				
Heart disease				
Stroke				
Lung disease				
Diabetes				
Inflammatory bowel disease				
Osteoporosis				
Cancer				
Other				

Social/Environmental History:

With whom do you / child / patient primarily live: _____

Occupation / Grade in school: _____ ❑ Home/Family manager ❑ No Daycare (Stays at Home)

❑ Preschool ❑ Grade School ❑ Junior/Middle School ❑ High School ❑ College

Pets/Animals at home: ❑ None ❑ Cat(s) ❑ Dog(s) ❑ Rabbit(s) ❑ Guinea Pig(s) ❑ Bird(s) ❑ Horse(s) ❑ Other: _____

Does anyone inside the home smoke? ❑ Yes ❑ No

Do you smoke or are you a former smoker? ❑ Yes ❑ No *If yes, (please circle)* ***vape*** *or* ***cigarettes****;*

Do you use Tobacco? ❑ Yes ❑ No *___ packs per day for ___ years. Quit ___ years ago.*

Do you drink alcohol? ❑ Yes ❑ No

Do you use any drugs/medications recreationally? ❑ 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? ❑ Central air ❑ Window units ❑ Swamp cooler ❑ 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 the patient) follow a special diet? ❑ Yes ❑ No

If yes, please describe: _____

Have you (or the patient) traveled internationally? ❑ Yes ❑ No If yes, when/where: _____

Review of Systems: Please **mark** any symptoms the patient has experienced recently.

Constitutional*:* ❑ *Fever* ❑ *Chills* ❑ Fatigue ❑ Loss of appetite ❑ Weight loss ❑ Weight gain ❑ Sleep problems

Skin*:* ❑ *Rash* ❑ Itching ❑ Hives ❑ Dryness ❑ Frequent skin infections

Eyes*:* ❑ *Itchy eyes* ❑ Red eyes ❑ Burning eyes ❑ Watery eyes ❑ Swollen eyes ❑ Visual disturbances

Ears*:* ❑ *Itchy ears* ❑ Frequent ear infections ❑ Ear tubes

Nose*:* ❑ *Itchy nose* ❑ *Sneezing* ❑ *Runny nose* ❑ *Nasal congestion* ❑ Nose bleeds ❑ Nasal polyps
❑ Sinus pressure ❑ Sinus pain ❑ Frequent sinus infections

Mouth/Throat*:* ❑ *Itchy mouth* ❑ Swollen mouth ❑ *Heartburn* ❑ *Difficulty swallowing (food stuck)* ❑ Painful swallowing

Respiratory*:* ❑ *Cough* ❑ *Shortness of breath* ❑ *Wheezing* ❑ *Chest tightness* ❑ Exercise intolerance
❑ Frequent pneumonias ❑ Coughing up blood

Cardiovascular*:* ❑ *Chest pain* ❑ Palpitations ❑ History of fainting ❑ *High blood pressure* ❑ Taking beta-blockers (ends in lol)

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

Hematologic/Oncologic*:* ❑ Anemia ❑ Easy bleeding or bruising ❑ *Prone to blood clots* ❑ History of blood transfusion
❑ Cancer

Allergic/Immunologic*:* ❑ Anaphylaxis (severe allergic reaction) ❑ Stinging insect anaphylaxis ❑ Penicillin allergy
❑ *NSAID allergy* ❑ *Metal allergy* ❑ *Latex allergy* ❑ Frequent infections

Neurological*:* ❑ *Headache* ❑ Migraines ❑ Seizures ❑ Learning problems ❑ Numbness/tingling in extremities

Psychiatric*:* ❑ Stress ❑ *Depression* ❑ *Anxiety* ❑ Behavioral problems