Southdale Pediatric Associates Allergy and Asthma Clinic
Medical History

Date of Visit _____ **Referring MD** _____
Name _____ **DOB** _____ **Primary MD/Clinic** _____
Reason for visit: _____
Drug Allergies: _____
Pharmacy: _____ **Location:** _____ **Phone:** _____

Allergy History	Yes	No
Do you have breathing problems?		
Do you have asthma?		
Did you ever smoke?		
Do you have sinus infections?		
Do you have nasal drainage?		
Do you sneeze frequently?		
Do you have any swelling?		
Do you react to drugs?		
Do you react to bee stings?		
Have you had allergy tests?		
Have you had allergy shots?		
Do you get frequent infections?		

Circle your skin concern:
eczema hives blisters other
When did the problem start? _____
No. of cigarettes per day/ # of years? _____
Do you react to foods? If yes, please list: _____
_____
Do you have seasonal allergy symptoms? If yes, list months: _____

Smokers in home? Yes No
Do you have any pets/animals? _____
What kind? _____
Your bedding material: _____
Heat source type:_____
Occupation:
_____
School or work exposure:
_____
Hobbies:
_____

Prescription and Over the Counter Current Medications:	Refills Needed (please circle):	
	Y	N
	Y	N
	Y	N
	Y	N
	Y	N
	Y	N

Past Medical & Surgeries	Yes	No
Do you have heart disease?		
Do you have diabetes?		
Do you have emphysema?		
Do you have high blood pressure?		
Do you have thyroid disease?		
Do you have inflammatory bowel disease?		
Have you had sinus surgery?		
Do you have any autoimmune diseases?		
Immunizations up to date?		

ROS Circle any present symptoms:

General	weight loss fevers fatigue sweats
Eye	red dry blurry itchy watery pain
Nose	itch congested drainage bloody no smell
Ear	ringing pain plugged hearing loss itch
Throat	pain difficult swallow hoarse itchy
Heart	chest pains faint palpitations
Lungs	shortness of breath cough wheeze phlegm
GI	abdominal pain nausea vomiting constipation diarrhea heartburn
Joint	stiffness pain swollen warm
Neuro	numbness tingling headache weak
Endo	heat/cold tolerance excess thirst
Psych	depression anxiety suicidal thoughts
Skin	itchy burning redness scaly dry

List other medical problems/surgeries: _____
_____

SOUTHDALE PEDIATRIC ASSOCIATES PATIENT FAMILY HISTORY

NAME_____ DATE OF BIRTH_____

FAMILY HISTORY
Please indicate if there is any family history of the following:

MEDICAL CONDITION	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMOTHER	PATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDFATHER	OTHER
ALLERGIC RHINITIS									
ASTHMA									
BLEEDING DISORDER									
CELIAC DISEASE									
DIABETES									
DRUG ABUSE									
FOOD ALLERGIES									
GENETIC DISEASE									
HEART DISEASE									
KIDNEY DISEASE									
LEARNING PROBLEMS									
MENTAL ILLNESS									
MIGRAINE									
OBESITY									
RECURRENT SINUS INFECTION									
SEIZURES									
SKIN CONDITION									
THYROID DISEASE									
OTHER									