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?		
Do you wheeze?		
Do you cough?		
Did you ever smoke?		
Do you have sinus infections?		
Do you have nasal congestion?		
Do you have nasal drainage?		
Do you sneeze frequently?		
Do you have itchy eyes?		
Do you have itchy throat?		
Do you have itchy skin?		
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?		
Do you have rashes?		

Circle your rash: 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 any hay fever? If yes, list months: ________
____

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

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

Immunizations up to date? Yes No
List other medical problems/surgeries: ________
____
____

Social & Family History	Yes	No
Parent (s) with asthma?		
Parent (s) with allergy?		
Other family with allergy/asthma?		
Family with recurrent infections?		
Family with eczema/hives?		
Family with autoimmune disease?		

Circle: Rheumatoid Arthritis Thyroid MS Crohns Lupus
Home environment: Smokers in home? Yes No
Dogs at Home? How many? ________ Bedding? ________
Other furry pets? ________ Heat Source? ________
Occupation: ________
School or work exposure: ________
Hobbies: ________

Patient/Parent Signature ________________
MD signature ________________, M.D