David Axelrod, M.D., F.A.A.A.A.I.
Allergy, Asthma and Immunology

Patient History Form

Please type your name and birth date.

Name: _____ Birth Date:_____

Doctor who asked you to see me for allergy or immunology problems:

_____

Name

_____

Street Address

_____ _____ _____

City State Zip Code

_____ _____

Telephone Number FAX Number

Please check all that apply to you:

Eyes: ☐ Right Eye ☐ Left Eye ☐ Both Eyes How Long: _____

☐ Itchy ☐ watery ☐ pus ☐ pain

Nose: ☐ Right Side ☐ Left Side ☐ Both Sides How Long: _____

☐ Itchy ☐ runny ☐ stuffy ☐ blood ☐ pain

Lungs:

☐ Shortness of breath ☐ cough ☐ Wheeze ☐ tight chest how long: _____

☐ Causes me to awaken at night How many times per week? _____

Are you able to do your usual activities? ☐

Worse with: ☐ cold ☐ heat ☐ exercise

☐ Foods Which foods: _____

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Rash: ☐hives ☐swelling ☐eczema

Where is rash: _____

Does it cause trouble breathing: ☐

Worse with: ☐cold ☐heat ☐exercise ☐sun

☐Vibration ☐what you wear: _____

☐Food: What food: _____

Infections:

How many per year: _____

Where: ☐sinus ☐throat/mouth ☐bronchial tree ☐lungs

☐Urinary bladder ☐skin

When do your symptoms bother you: ☐Spring ☐Summer ☐Fall ☐Winter

Are you worse: ☐by freshly cut grass ☐cat ☐dog ☐horse

☐Hamster ☐guinea pig ☐mice

Other: _____

☐In a damp area:

☐When you go from the cold to the warm

☐With changes in weather ☐with stress ☐with smoke

☐With strong perfumes ☐when you read a newspaper

Are you worse with: ☐kiwi ☐papaya ☐chestnut ☐grapefruit

☐Banana ☐mango ☐avocado

☐Plastic gloves ☐When you blow up a balloon

☐Foods Which foods: _____

Have you been stung by: ☐bee ☐wasp ☐hornet ☐yellow jacket

What happened: _____

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What type of work do you do: _____

Are you worse at work: ☐

To what are you exposed at work: _____

You live in a: ☐house ☐apartment How old is house/apartment: _____

For how long have you lived there: _____

Do you have a: ☐ basement ☐ crawl space ☐ none

Is it: ☐ damp ☐ dry

Do you use: ☐ humidifier ☐ dehumidifier

☐ Air conditioning ☐ central ☐ window

How often change filter: _____

What type of heat do you use:

☐ Forced air ☐ oil ☐ electric ☐ hot water

☐ Baseboard ☐ radiator

In your bedroom do you use:

Pillow ☐ synthetic ☐ feather ☐ cotton ☐ foam ☐ dust covers

☐ Mattress ☐ box spring ☐ water bed ☐ dust cover

Bedcover ☐ synthetic ☐ feather ☐ wool ☐ cotton

☐ Wood floor ☐ area rug ☐ carpet

☐ Area rug is washable ☐ area rug is NOT washable

How often do you vacuum the carpet: _____

In your home you have: ☐ cat ☐ dog other animal: _____

Does the pet come into your bedroom: ☐

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Have you ever had:

☐ High blood pressure ☐ high cholesterol ☐ heart trouble

☐ Heart murmur ☐ stroke ☐ blood clots ☐ kidney trouble

☐ Liver trouble ☐ complicated pregnancy ☐ cancer ☐ allergies

☐ Arthritis ☐ Hepatitis ☐ HIV ☐ Miscarriages How many: _____

Other: _____

Have you ever had any surgery:

☐ Appendectomy ☐ Gall bladder surgery ☐ Prostate surgery ☐ Uterus

☐ Ovaries ☐ breast ☐ heart ☐ joints Which joints: _____

Other: _____

Do you: ☐ smoke ☐ drink alcohol ☐ illicit drugs

How many per week: _____

Have you been vaccinated against:

☐ Small pox ☐ Seasonal influenza ☐ H1N1

☐ Pneumococcus ☐ Tetanus ☐ Diphtheria ☐ Pertusis

☐ Measles ☐ mumps ☐ rubella ☐ hemophilus

☐ Hepatis A ☐ Hepatitis B

Have you had a TB skin test: ☐ When: _____

Have you had a chest X-ray: ☐ When: _____

Please list the names of the prescription and non-prescription medication that you take.

Name of medication	Name of medication	Name of medication

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Please check any of the medications below, that you have already taken.

Anti-histamines/Drying nasal spray:

☐ Benadryl ☐ Chlortrimeton ☐ Claritin ☐ Clarinex ☐ Allegra

☐ Zyrtec ☐ Xyzal ☐ Astelin ☐ Patanase ☐ Atrovent nasal spray

Nasal sprays:

☐ Vansenase/Beconase ☐ Nasalcrom ☐ Nasalide ☐ Nasacort

☐ Nasonex ☐ Rhinocort ☐ Flonase ☐ Omnaris

Eye drops:

☐ Accular ☐ Alocril ☐ Alomide ☐ Crolom ☐ Elestat ☐ Emadine

☐ Livostin ☐ Optivar ☐ Patanol ☐ Zatidor ☐ Zyrtec

Sprays for Asthma:

☐ Vanceril/Beclovent ☐ Aerobid ☐ Azmacort ☐ Flovent ☐ Pulmicort

☐ Alvesco ☐ Advair ☐ Symbicort ☐ Atrovent ☐ Spireva

☐ Proventil ☐ Xopenex ☐ Serevent ☐ Foradyl

Injectables:

☐ Xolair ☐ Cinryze

Other medications that you have taken for your problem, for which you come to see me:

Name of medication	Name of medication	Name of medication

Medications to which you had a reaction:

Name of medication	Reaction you suffered	Name of medication	Reaction you suffered

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Do you suffer from any of the following problems?

General:

☐ Fever ☐ chills ☐ sweats ☐ weight loss ☐ weight gain

☐ Low blood count

Head:

☐ Headache ☐ dizziness ☐ lightheadedness

Eyes:

☐ Worsening of vision ☐ double vision ☐ pain ☐ discharge from eyes

Ears:

☐ Worsening of hearing ☐ spinning sensation ☐ ringing in ears ☐ pain

☐ Discharge from ear

Nose:

☐ Damage to nose ☐ blood from nose ☐ pus from nose ☐ odd odors

☐ Deviated septum ☐ change in smell

Throat/Mouth:

☐ Sore throat ☐ change in taste ☐ sore tongue ☐ large tongue

☐ Repair of teeth

Chest:

☐ Pain ☐ cough ☐ shortness of breath ☐ cough up blood

☐ Breast mass ☐ breast discharge ☐ breast pain

Heart/Blood Vessels:

☐ Chest pain ☐ rapid heart rate ☐ shortness of breath with activity ☐ heart murmur

☐ Heart attack ☐ angina ☐ rheumatic fever ☐ sleep on more than 1 pillow

☐ Pain in legs when you walk ☐ fingers turn red/white/blue in cold

Intestinal tract:

☐ Loss of appetite ☐ nausea ☐ vomiting ☐ vomiting with blood

☐ Heart burn ☐ discomfort in abdomen ☐ constipation ☐ turned yellow

☐ Loose stool ☐ change in size of stool ☐ blood in stool

☐ Black and tarry stool

Genitourinary tract:

☐ Trouble holding urine ☐ trouble urinating ☐ blood in urine

☐ Bladder infections How many per year: _____

☐ Pass urine in night time How many times per night: _____

☐ You have regular periods ☐ You have periods that are not regular

☐ History of sexually acquired disease ☐ genital sores

Neuromuscular:

☐ Loss of consciousness ☐ lightheadedness ☐ spinning

☐ Weakness ☐ numbness ☐ seizures ☐ coma ☐ mood problems

Rheumatic:

☐ Stiff after awakening ☐ tire during the day ☐ stiff during the daytime

☐ Trouble falling asleep due to pain ☐ awaken at night because of pain

☐ Rash ☐ rash with sun exposure ☐ pain in eyes due to sun exposure

☐ Sores in mouth ☐ pink eye ☐ emotional problems ☐ fluid around heart/lungs

☐ Low blood counts ☐ darkening of your urine ☐ blood in urine

☐ Loss of strength in hands ☐ loss of strength in feet ☐ tight skin

☐ Blood clots ☐ miscarriages ☐ trouble getting out of a chair

Thank you!