MEDICAL HISTORY FORM

Patient Name:___________________________ Date of Birth: _______________

- ➢ **Please complete the sections below that apply to you/your child and each of the required sections.**
- ➢ **Please note that this form needs to be returned to our office <u>at least 48 hours prior to the scheduled appointment</u>.**

Food Allergy History *If applicable*

Food (peanut, milk, unknown etc.)	*Allergy testing* Skin and/or blood test? Date?	*Reaction history* Date of reaction(s)?	*Reaction symptoms* (hives, wheezing, etc.)	*Reaction treatment* (Benadryl, epinephrine, etc.)

***If labs have been performed, please request that they be transferred to our office and call the office at least 48 hours prior to the visit to ensure the requested labs have been received.**

Are you presenting today specifically for consultation regarding our Oral Immunotherapy (OIT) program? https://aafacenters.com/our-services/food-allergy-center/

YES NO

Environmental Allergy History

Has the patient ever been diagnosed with seasonal/environmental allergies? YES NO

If YES, please complete this section.

- Has environmental allergy testing been done in the past 5 years? YES NO
- Which known allergens/seasons? ____
- Which medicines does the patient take?____
- Has the patient ever been on allergy shots? YES NO

If NO, please complete this section.

- Does the patient have itchy eyes, a runny nose, or sneezing that is not associated with a cold or other illness? YES NO

If there is a known or suspected history of allergies/hay fever:

Does the patient experience oral, throat or ear itching with fresh fruits or vegetables? YES NO

Does the patient experience increased allergy symptoms around animals? YES NO

If yes, which animals (dog, cat, etc)? ____

Dermatologic History

Has the patient had unexplained prolonged or recurrent episodes of hives and/or swelling?
YES NO

If YES, please complete this section.

- Is this an ongoing problem? YES NO
    - If Yes, when did this start? ____
- Which medicines does the patient take for this?__________________________________

Has the patient ever been diagnosed with atopic dermatitis (eczema)? YES NO
Is this an ongoing problem? YES NO

If eczema is current, which medications and/or moisturizers are used and how often are they applied?

____

If NO, please complete this section.

- Is eczema suspected due to an itchy or scaly rash on the face/arms/legs/trunk?
YES NO

Respiratory History

Has the patient been diagnosed with asthma, experienced recurrent episodes of wheezing or had to use albuterol on more than one occasion? YES NO
Are symptoms current (occurred in the past 2 years vs present several years ago and now resolved) YES NO

If YES or if the patient is a child presenting for food allergy, please complete this section.

- Does the patient have difficulty sleeping at night due to cough, wheezing, or any trouble breathing from their lungs? YES NO
- Does the patient have difficulty running/ playing due to cough, wheeze, or any trouble breathing? YES NO

- Has the patient ever required treatment with oral steroids (prednisone/prednisolone/OraPred) for respiratory/breathing issues? YES NO
    - If yes, how many times in the past 12 months? ____________________________
- For adult patients, is there a history of COPD? YES NO

If there is a history of diagnosed asthma/suspected asthma, please also complete this section.

- What inhaler(s) is the patient currently using? ____
- How often does the patient use albuterol (nebulizer/rescue inhaler)?________________
- Has the patient been hospitalized for asthma? YES NO
- Has the patient been to Urgent Care or the ER for asthma in the last 12 months? YES NO

Gastrointestinal History

Does the patient have a known history of reflux or heart burn? YES NO

Are symptoms current (vs present in the past and now resolved)? YES NO

	Y	N
Does the patient complain of food getting stuck in his/her throat?		
Does the patient have difficulty swallowing?		
Is the patient consistently the last family member to finish eating?		
Does the patient have difficulty feeding, feeding refusal, or poor appetite?		
Does the patient have poor growth, malnutrition, or weight loss?		
Does the patient have reflux-like symptoms (wet burps, hot spits, throwing up in mouth, heartburn, indigestion….)?		
Does the patient have frequent vomiting?		
Does the patient have a known diagnosis of eosinophilic esophagitis (EoE)?		
Is there anyone in your family with a known diagnosis of EoE?		
Has anyone in your family f had an esophageal dilation (stretching of the esophagus due to it being too narrow)?		

Is there anything you would like us to know before the visit or regarding the visit?

____

____

____

IMMUNIZATIONS

Are immunizations up to date? YES NO

Has the patient received an influenza vaccine in the last year? YES NO

If age appropriate, has the patient been vaccinated for COVID? YES NO

Please note that ALL vaccines must be up to date to participate in our Oral Immunotherapy (OIT) program.

MEDICATION ALLERGIES:

- ☐ None
- ☐ Penicillin
    - ☐ Reaction, age, and day of medication symptoms occurred (if known) ______________________________
- ☐ Sulfa
    - ☐ Reaction: ______________________________
- ☐ Latex
    - ☐ Reaction: ______________________________
- ☐ Other(s) ______________________________

PAST MEDICAL PROBLEMS. Please check all that apply.

- ☐ ADD/ADHD
- ☐ Anxiety/Depression
- ☐ Asthma
- ☐ Autism Spectrum Disorder
- ☐ Cancer ________________
- ☐ Chronic sinusitis
- ☐ COPD
- ☐ Diabetes
    - ☐ Type 1
    - ☐ Type 2
- ☐ Eczema/ atopic dermatitis
- ☐ Eosinophilic Esophagitis
- ☐ Food allergy
- ☐ GERD/Reflux
- ☐ Hives (other than with an allergic reaction)
- ☐ Hyperlipidemia (High cholesterol)
- ☐ Hypertension (High blood pressure)
- ☐ Immunodeficiency
- ☐ Kidney problems ________________________

- ☐ Liver problems
  ____
- ☐ Lupus
- ☐ Nasal polyps
- ☐ Rheumatoid Arthritis
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Thyroid disorder
- ☐ Venom (bee/wasp/hornet) allergy
- ☐ Other(s):
  ____
  ____
  ____

SURGICAL HISTORY. Please check all that apply.

- ☐ Adenoidectomy
- ☐ Ear tubes
- ☐ Sinus or nasal surgery
- ☐ Tonsillectomy

SMOKING HISTORY

Are there smokers in the home? YES NO

Please check the box below that best describes you?

- ☐ Never smoker
- ☐ Current every day smoker
- ☐ Current some day smoker
- ☐ Former smoker

If you are a current smoker, please list packs per day smoked ______________________

FAMILY HISTORY:

- ☐ **Not known/Adopted**

Mother (M), Father (F), Sister (S), Brother (B), Paternal grandmother (PMG), Paternal grandfather (PGF), Maternal grandmother (PGM), Paternal grandfather (PGF). Maternal aunt (MA), Maternal uncle (MU), Paternal aunt (PA), Paternal Uncle (PU)

	M	F	S	B	MGM	MGF	PGM	PGF	MA	MU	PA	PU
Asthma												
Allergic Rhinitis												
Chronic Hives												
Swelling Episodes												
Cystic Fibrosis												
Eosinophilic Esophagitis												
Food Allergy												
Immunodeficiency												

Crohn's/ Ulcerative Colitis												
Lupus												
Rheumatoid Arthritis												
Thyroid Disease												

ADDITIONAL SOCIAL HISTORY

Are there pets at home? YES NO
If yes, please list: ____

Occupation/Grade: ____

Do you reside in? Single family home Apartment/condo Other ______________

When was your home built? _________ Is there central air/forced heat (Yes/No)? _________

Is there known water or mold damage in the home (Yes/No)? _________

Are there allergy covers on the pillows (Yes/No)? __________ on the mattress (Yes/No)? ____________

If a child, with whom does he/she reside: Both parents Mother Father Splits time b/w parents
Other: ____

MEDICATIONS Or may attach medication list

Name	Strength	Form	Frequency
Ex. Zyrtec	**10mg**	**Tablet**	**As needed**