SHER ALLERGY SPECIALISTS

A Division of Florida Pediatrics Association, LLC
11200 Seminole Blvd., Suite 310, Largo FL 33778
(727) 397-8557

Patient's name: _____ Date of Birth: _____

INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete, accurate Record is important in learning about your allergy problem.

1. Briefly, describe the reason for your allergy visit and what you hope to accomplish:

_____

_____

2. PROBLEMS: Have you ever had the following problems or conditions:

Yes	Check all items that apply	Age at onset	Severity Mild, Moderate or Severe
	Asthma		
	Any other breathing problems		
	Sinus trouble		
	Hay Fever (Nasal Allergies)		
	Hives or swelling		
	Eczema or other rashes		
	Frequent infections		
	Insect reactions		
	Latex allergy		
	Metal allergy		

3. DRUG/MEDICATION/IMMUNIZATION ALLERIES & INTOLERANCES:

List all drug allergies and the reactions (hives, rash, nausea, vomiting, diarrhea, difficulty breathing, etc.

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

4. MEDICATIONS (INCLUDING OVER-THE-COUNTER):

MEDICATION NAME	STRENGTH	DAILY FREQUENCY	MEDICATION NAME	STRENGTH	DAILY FREQUENCY
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

5. MEDICAL HISTORY (HAVE YOU EVER BEEN DIAGNOSED WITH) CHECK ALL THAT APPLY

◯ Anemia	◯ Diabetes Type 1 or Type 2:	◯ Irritable bowel syndrome	◯ Osteopenia/Osteoporosis
◯ Anxiety	◯ Fibromyalgia	◯ Jaundice/liver disease	◯ Pneumonia/Lung disease
◯ Arthritis Osteo or Rheumatoid	◯ Glaucoma	◯ Kidney disease	◯ Prostate problems
◯ Atrial fibrillation	◯ GERD/heartburn	◯ Low back pain	◯ Seizures/Epilepsy
◯ Bleeding Disorder	◯ Heart attack	◯ Migraines/Headache	◯ Sleep Apnea
◯ Cancer What kind?	◯ Heart disease	◯ Menopause	◯ Sleep disturbances
◯ Cataracts	◯ Heart failure	◯ Menstrual irregularities	◯ Thyroid disease
◯ Colon Polyps	◯ High blood pressure	◯ Neuropathy	◯ Ulcers
◯ Depression	◯ High cholesterol	◯ Obesity	◯ Urinary incontinence

Other:

6. SURGICAL HISTORY (List any surgeries or procedures you have had performed)

Procedure	Date	Procedure	Date
1.		4.	
2.		5.	
3.		6.	

7. HOSPITALIZATIONS (List ANY hospitalizations):

WHY?	Date	WHY?	Date
1.		4.	
2.		5.	
3.		6.	

8. FAMILY HISTORY: Please indication if your blood relative (s) have had/currently have the following:

Family Member	Alive	Deceased	Year of birth/age	Asthma	Allergic Rhinitis/Hay Fever	Food Allergy	Drug Allergy	Diabetes	Hypertension/High blood pressure	Heart Disease	Mental Illness	Unknown
Mother												
Father												
Son(s)												
Daughter(s)												
Sibling(s)												

9. REVIEW OF SYSTEMS CHECK ALL THAT APPLY

◯ Fatigue	◯ Diarrhea	◯ Weakness	◯ Irregular heartbeat
◯ Fever	◯ Vomiting	◯ Fainting	◯ Abdominal pain
◯ Disordered Sleep	◯ Bruising	◯ Anxiety	◯ Joint pain
◯ Weight Changes	◯ Bleeding	◯ Depression	◯ Constipation
◯ Muscle pain	◯ Urinary urgency	◯ Urine frequency	

10. BIRTH HISTORY: PLEASE COMPLETE THE FOLLOWING FOR DEPENDENT CHILDREN UNDER 18 YEARS OF AGE.

Place of birth: _____ Age of mother at birth: _____

Was pregnancy normal? _____ If no, please specify reason: _____

_____

Was delivered by: C-Section -or- Vaginal Patient was: Formula fed -or- Breastfed

11. MARITAL STATUS: ◯ Married ◯ Single ◯ Widowed ◯ Separated ◯ Divorced

Number of Children: _____

12. RESIDENCE: LIST YOUR PAST RESIDENCES WITH YOUR MOST RECENT FIRST. LIST ONLY CITY AND STATE.

City & State	How long?	Symptoms better?	Symptoms worse?	No change

13. WORK ENVIRONMENT:

What type of work do you do? _____ Where are you employed? _____
Is your work environment: ⬭Carpeted? ⬭ Tiled?
Are you exposed to chemicals or strong odors or anything that might aggravate your condition? _____
If yes, please specify: _____

14. SCHOOL ENVIRONMENT:

What school do you attend? _____
What grade? _____
Have you missed school because of your allergies? _____ How many days in last year? _____
Do you feel extra-curricular activities have been affected by your condition? _____

15. ENVIRONMENTAL SURVEY:

Approximate age of house:	How old is your Pillow? _____ Mattress? _____
Are any rooms damp or musty?	Is your pillow: ⬭feather ⬭foam rubber ⬭Dacron ⬭ encased in plastic ⬭other: _____
Type of heating? (Electric, gas, central, etc.?)	Is your mattress: ⬭ innerspring ⬭ foam rubber ⬭ waterbed ⬭ encased in plastic ⬭other: _____
Do you have: ⬭air cleaner ⬭Air dehumidifier	Are your sheets washed in: ⬭ cold ⬭ warm ⬭ hot
How often do you change/clean your air conditioner and air cleaner filters?	Do you have any: ⬭ Stuffed furniture ⬭ Feather comforters ⬭ Stuffed animals
Is the home: ⬭ carpeted ⬭ tiled	Do you have any pets? (List number and kind)
Is the bedroom: ⬭ carpeted ⬭ tiled	Other:

16. SOCIAL HISTORY:

Have you ever smoked? ⬭Yes ⬭No If yes, how many years? _____
Do you presently smoke? ⬭ Yes ⬭No If no, when did you stop? _____
Average cigarettes per day at highest point? _____
If you still smoke, do you think you could stop? _____
Do you or family members smoke: In the house? _____ In the car? _____
Which other family members now smoke? _____

Do you drink alcohol? ⬭ Yes ⬭ No If yes, list type _____
Average weekly consumption? _____

Do you consume caffeine? ⬭ Yes ⬭ No If yes, how many caffeine drinks do you consume in a day? _____

Do you use drugs other than for medical reasons? ⬭ Yes ⬭ No If yes, list type _____