

MEDICAL HISTORY

Texas Allergy Center
Jane J. Lee, M.D.

Name: _____ Date: _____

Sex: () Male () Female DOB: _____ Age: _____

Did a physician refer you to see us? () Yes () No

If yes, Doctor's Name: _____

Primary Care Physician's Name: _____

If a physician did not refer you, how did you hear about us? _____

Reason for Visit: _____

Duration of Condition: _____

Describe the most distressing symptoms you feel are caused by your allergy:

List all medications you have tried in the past for allergy (all oral, topical and nasal sprays) and the response you had to each:

Have you ever had an allergy skin test? () Yes () No

Date of Testing: _____ Physician's Name: _____

Have you ever been on allergy shots? () Yes () No Date(s): _____

Have you had sinusitis? () Yes () No Frequency: _____

Have you ever had a sinus X-ray or CT? () Yes () No Date(s): _____

Do you have Asthma? () Yes () No

List family members with allergy problems: _____

Have you tested positive for: () HIV () Hepatitis B () Hepatitis C

Social History:

How long have you lived in Dallas? _____

How long have you lived in your current home? _____ years _____ months

Is there any obvious mold problem? () Yes () No Area in home: _____

Type of flooring (include bedroom): _____

History of smoking: () Yes () No How Long? _____ Packs Per Day: _____

Prolonged cigarette smoke exposure: () Yes () No

Occupation: _____

Hobbies: _____

Pets: () Dog () Cat () Other: _____

() Indoor () Outdoor () Both

Review of Systems (please circle all symptoms you may have):

Headaches

Sinus pain

Eyes: Redness

Tearing

Itch

Puffiness

Nose: Colds

Discharge

Stuffiness

Hay fever

Itch

Bleeding

Sneezing

Snoring

Sinusitis

Ears: Frequent infection

Pain

Hearing loss

Chest: Asthma

Chronic cough

Shortness of breath

Bronchitis/pneumonia

Skin: Eczema

Contact dermatitis

Angioedema/hives

Dry

Itchiness

Atopic dermatitis

GI: Nausea/vomiting

Appetite changes

Reflux symptoms

Lactose intolerance

Changes in bowel habits

GU: Infection

Incontinence

General: Weight loss/gain

Emotional problems

Sleep pattern

Missed school/work

Females:

Abnormal menstrual periods

Menopause

Past Medical History:

History of Surgery (Include sinus surgery):

Known Allergies to Medications (List names and symptoms you had):

All Current Medications (include allergy medications):

(Women only)

Are you currently or might be pregnant? _____ Yes _____ No

Are you planning or attempting to become pregnant in the near future? _____