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? _____