Medical History

Patient Name: _____ DOB: _____

Date: _____

1. Are you on any blood pressure medication? YES / NO
2. Are you on any heart medications? YES / NO
3. Have you ever had a stroke? YES / NO
4. Have you ever been diagnosed with or do you have a history of cardiovascular disease? YES / NO
5. Have you ever had a severe anaphylactic reaction *(severe allergic reaction)* that required emergency medical attention? YES / NO
6. Are you a moderate / severe asthmatic? YES / NO
7. Within the past year have you had an allergy scratch test? YES / NO
8. Within the past year have you had Immunotherapy Medication made for you? YES / NO
9. Do you have a history of taking any allergy medications including allergy shots? YES / NO
   If yes, please state what type: _____
10. Are you pregnant? YES / NO
11. Have you tested positive for HIV? YES/NO

If there is a possibility that you are pregnant please notify the physician before you have the allergy test.

_____ _____
Patient Signature Date

Notes: _____
_____
_____
_____
_____

_____ _____
Physician Signature Date

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Chart Update

Name: _____ Date: _____
Contact Number: _____ DOB: _____

1. Do you experience any of the following symptoms: running nose, itchy nose, stuffy nose, itchy and/or watery eyes, or frequent sneezing? If you do, you may have allergies.

Is your medical history consistent with the symptoms above?
Yes No

2. Overall what is the severity of your allergy symptoms?
Mild Moderate Severe

3. Are your allergy symptoms present (please circle)
Rarely Seasonally (e.g. Summer/Spring only) ** Most of the year ***

4. Please circle the symptoms you suffer from and then circle the severity of the symptom(s).

a. Stuffy Nose	Mild *	Moderate **	Severe ***
b. Runny Nose	Mild *	Moderate **	Severe ***
c. Itchy Eyes	Mild *	Moderate **	Severe ***
d. Watery Eyes	Mild *	Moderate **	Severe ***
e. Itchy Throat	Mild *	Moderate **	Severe ***
f. Sneezing	Mild *	Moderate **	Severe ***

5. How often do you take prescription or over-the-counter medications for your allergies?
Not at all * Sometimes ** Frequently ***

6. Do you suffer from side effects such as dry mouth, drowsiness, or other effects?
Not at all * Sometimes ** Frequently ***