Name:______________________ Date:__________________

PALMETTO ALLERGY & ASTHMA, PA

New Patient Evaluation

PAST MEDICAL HISTORY

We need to know if you have had either an allergic or adverse reaction to any drug, food or insect sting. We need to know the name of the drug, food or insect that you had a reaction to. Please list symptoms such as hives/welts, swelling, shortness of breath, wheezing, throat tightness, loss of consciousness, rash, nausea, vomiting, diarrhea. Please include the date the reaction occurred. Also include the amount of time between ingestion of the drug or food , or insect sting and the beginning of the reaction. (For example, aspirin or shrimp was taken and the reaction started 30 minutes later.) Include any treatment that was needed such as emergency room visits, doctor visits, or over the counter medicines.

Drug Allergies or Adverse Drug Reactions:

DRUG		WHAT SYMPTOMS	DATE	Time of ingestion	Time of rxn	TREATMENT
______________	CAUSED	______________	______	__________	________	________
______________	CAUSED	______________	______	__________	________	________
______________	CAUSED	______________	______	__________	________	________
______________	CAUSED	______________	______	__________	________	________

What drugs do you routinely avoid?____

Adverse Food Reactions

FOOD		WHAT SYMPTOMS	DATE	Time of ingestion	Time of rxn	TREATMENT
______________	CAUSED	______________	______	__________	________	________
______________	CAUSED	______________	______	__________	________	________
______________	CAUSED	______________	______	__________	________	________

What foods do you routinely avoid?____

INSECTS		WHAT SYMPTOMS	DATE	Time of sting	Time of rxn	TREATMENT
______________	CAUSED	______________	______	__________	________	________
______________	CAUSED	______________	______	__________	________	________
______________	CAUSED	______________	______	__________	________	________

Have you been stung by the same insect again? Yes, No If yes, did you have any reaction? Yes, No (describe reaction)______

____

Do you have an Epi-Pen or Epi-Pen, Jr? YES NO

REVIEW OF SYSTEMS: Please answer yes or no to the following. Please answer yes only if this is a persistent symptom. If you answer yes, please list doctor, if any, who is treating this symptom.
Have you had in the LAST YEAR:

Symptom	Yes	No	M.D. Treating	Symptom	Yes	No	M.D. Treating
Daily unexplained fever				Joint pain			
Unexplained weight loss				Blurred vision			
Night sweats				Seizures			
Enlarged lymph nodes				Any hormone problems			
*Chest pain				Any psychiatric problems			
*Irregular heart rhythm				Anemia/low blood count			
*Heart murmur				Dry, scaly itchy skin			
*Heartburn				Itchy, red welts (hives)			
Chronic diarrhea				Swelling eyes, lips, feet, hands			
Chronic nausea				Severe itching (no rash)			
Prostate problems							
Frequent urination							

All Patients Please Complete

Please list all hospitalizations and surgeries.

Age	Hospitalizations and reason for	Age	Surgeries

Please complete if the patient is less than 10 years of age. Please answer yes or no.
Full term infant: yes no Premature infant: yes no Bottle fed: yes no Breast fed: yes no
Any problems at birth: yes no (if yes, please describe)______________________________
Any problems with formula: yes no (if yes, please describe any symptoms or change in formula)
____
Any problems with introduction of solid foods: yes no (if yes, please describe)
____
At what age were solid foods introduced? Cereal_____months, Fruits_____months, Vegetables_____months
Any problem with starting whole milk? yes no (if yes, describe)
____
At what age was milk introduced into the diet?____________________
Does the patient routinely avoid any food at this time? yes no If yes, what food?__________________
Does the patient stay at home during the day? yes no Any other children in the home? yes no
Please list the ages of other children in the home______________________________
Does the patient go to daycare? yes no If yes, at what age did the patient start daycare?______________
Immunizations: Please check one _____ Yes, they are up to date _____ No they are not up to date
Has the patient had chickenpox? yes no If yes, when?______________________________
Has the patient had the chickenpox vaccine? yes no If yes, when?

All Patients Please Complete

Medical Illnesses- (problem list)- please answer yes or no to the following medical problems; if yes, please list how long you have had the problem and who treats you for this illness.

Medical Illness			How Long Present	M.D. Taking Care of Illness
High Blood Pressure	Yes	No		
Coronary Artery Disease (angina)	Yes	No		
History of Heart Attack	Yes	No		
Heart Bypass Surgery	Yes	No		
Angioplasty or Stent	Yes	No		
Congestive Heart Failure	Yes	No		
Mitral Valve Prolapse	Yes	No		
Heart Valve Problems	Yes	No		
Atrial Fibrillation	Yes	No		
Irregular Heart Rhythm	Yes	No		
High Cholesterol or Lipids	Yes	No		
Stroke or Mini Stroke (TIA)	Yes	No		
Seizures	Yes	No		
Autism	Yes	No		
Cerebral Palsy	Yes	No		
Blood Clots	Yes	No		
Sleep Apnea	Yes	No		
Emphysema	Yes	No		
Chronic Bronchitis	Yes	No		
HIV Positive	Yes	No		
Heartburn or Reflux	Yes	No		
Stomach Ulcers or GI bleeding	Yes	No		
Liver Disease (hepatitis)	Yes	No		
Ulcerative Colitis	Yes	No		
Chrohn's Disease	Yes	No		
Irritable Bowel Syndrome	Yes	No		
Anemia	Yes	No		
Low or High Platelets	Yes	No		
Diabetes	Yes	No		
Thyroid Disease	Yes	No		
Sarcoid	Yes	No		
Rheumatoid or Osteoarthritis	Yes	No		
Lupus	Yes	No		
Osteoporosis	Yes	No		
Cancer( )	Yes	No		
Depression	Yes	No		
Schizophrenia	Yes	No		
Manic-Depressive Disorder	Yes	No		
Panic or Anxiety Disorder	Yes	No		
ADD / Hyperactivity	Yes	No		
Obsessive Compulsive Disorder	Yes	No		
Psoriasis or Rosacea	Yes	No		
Eczema	Yes	No		