St. Paul Allergy & Asthma

PATIENT NAME: _____ **PREFERRED NAME/PRONOUNS:** _____
DATE OF BIRTH: _____ **TODAY'S DATE:** _____

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Primary Care Provider (Name/Clinic): _____
Referred by (Name/Clinic): _____
Can we send a letter back to your primary/referring provider(s)? ☐ **YES** ☐ **NO**

How did you hear about our practice?

☐ Doctor/healthcare provider ☐ Recommended by family member/friend ☐ Insurance search
☐ Google/online search ☐ Advertisement _____ ☐ Drive-by sighting
☐ Other _____

What are your primary goals for this visit/questions you have for your doctor?

☐ _____
☐ _____
☐ _____
☐ _____

PLEASE CHECK THE SYMPTOMS YOU ARE CURRENTLY/VERY RECENTLY EXPERIENCING:

GENERAL:
☐ Fatigue
☐ Fever
☐ Difficulty sleeping
☐ Anxiety
☐ Depression

EYES:
☐ Itchy
☐ Watery
☐ Red
☐ Puffy
☐ Vision changes

EARS/NOSE/SINUSES/THROAT:
☐ Stuffy nose
☐ Runny nose
☐ Sneezing
☐ Itchy nose
☐ Post-nasal drainage
☐ Facial pressure
☐ Poor sense of smell
☐ Nosebleeds
☐ Ear pain/fullness
☐ Snoring
☐ Sore throat
☐ Itchy throat

LUNGS:
☐ Chest tightness
☐ Cough
☐ Shortness of breath
☐ Sputum/phlegm
☐ Wheezing

HEART/BLOOD VESSELS:
☐ Chest pain
☐ High blood pressure
☐ Irregular heartbeat
☐ Swelling in hands/feet
☐ Color changes of skin

GI TRACT:
☐ Stomach pain
☐ Diarrhea
☐ Difficulty swallowing
☐ Heartburn
☐ Weight loss

SKIN:
☐ Eczema
☐ Hives
☐ Itching
☐ Swelling

MUSCLES/BONES:
☐ Joint pain
☐ Joint redness
☐ Joint swelling

ENDOCRINE:
☐ Dry mouth
☐ Cold intolerance
☐ Hot flashes

BLOOD:
☐ Swollen glands/nodes
☐ Anemia
☐ Easy bruising

NERVOUS SYSTEM:
☐ Dizziness
☐ Headache
☐ Pain
☐ Tingling/numbness

LOCAL PHARMACY:
Name: _____
City: _____
Cross-streets: _____

MAIL-ORDER PHARMACY:
Name: _____

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PAST MEDICAL HISTORY:

Check all that apply:

☐ Seasonal allergies
- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter
- ☐ All year symptoms

☐ Pet allergies
- ☐ Dogs
- ☐ Cats
- ☐ Rabbits
- ☐ Other _____
- ☐ Other_____

☐ Asthma/coughing/wheezing
- ☐ With illness
- ☐ With exercise
- ☐ With allergy symptoms
- ☐ With cold/humid air
- ☐ Around smoke/irritants

☐ Hives
- ☐ With heat exposure
- ☐ With cold exposure
- ☐ With pressure
- ☐ With friction/vibration
- ☐ Due to medications _____
- ☐ Due to foods _____

☐ Eczema
- ☐ In the winter/cold exposure
- ☐ In the summer/heat exposure
- ☐ With exposure to chlorine
- ☐ Due to foods _____
- ☐ Due to environmental allergies_____
- _____

☐ Food allergies -> list culprit foods: _____

_____

☐ Recurrent infections -> list:

_____

Other conditions:

☐ Heartburn/reflux	☐ COPD	☐ Thyroid disease	☐ Latex allergy
☐ Heart disease	☐ Kidney disease	☐ Liver disease	☐ Cancer
☐ Diabetes	☐ Anxiety/depression	☐ _____	☐ _____

Have you previously been tested for allergies? ☐ YES; when/where_____ ☐ NO

Did you previously take allergy shots? ☐ YES; how long/helpful? _____ ☐ NO

Do you have a penicillin allergy? ☐ YES; have you had testing_____ ☐ NO

Prior severe reaction to a bee/wasp/hornet sting? ☐ YES - have you had testing_____ ☐ NO

PAST SURGICAL HISTORY:

☐ Tonsillectomy (year_____)	☐ _____ (year_____)
☐ Adenoidectomy (year_____)	☐ _____ (year_____)
☐ Sinus surgery (year_____)	☐ _____ (year_____)
☐ Ear tubes (year_____)	☐ _____ (year_____)

PRIOR HOSPITALIZATIONS:

☐ _____ (year_____)	☐ _____ (year_____)
☐ _____ (year_____)	☐ _____ (year_____)

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MEDICATIONS:

☐ _____ ☐ _____ ☐ _____
☐ _____ ☐ _____ ☐ _____
☐ _____ ☐ _____ ☐ _____
☐ _____ ☐ _____ ☐ _____

MEDICATION ALLERGIES:

☐ _____ (reaction_____) ☐ _____ (reaction_____)
☐ _____ (reaction_____) ☐ _____ (reaction_____)
☐ _____ (reaction_____) ☐ _____ (reaction_____)

FAMILY MEDICAL HISTORY:

☐ Environmental allergies ☐ Asthma ☐ Eczema ☐ COPD
☐ Immune deficiency/severe infections ☐ _____ ☐ _____

SOCIAL HISTORY:

☐ Single ☐ Married ☐ Domestic partnership ☐ Widowed ☐ Divorced/separated ☐ Other
☐ No pet exposures ☐ Current pet exposures (type, location) _____
☐ Never used tobacco/vaping ☐ Prior use of tobacco/vaping ☐ Exposed to tobacco/vaping 2nd hand
☐ Current use of tobacco/vaping ☐ I am interested in quitting tobacco/vaping
☐ Travel outside the US in the past 6 months (list countries) _____
☐ Primary language _____ ☐ Race/ethnicity _____ ☐ Country of origin_____

WORKPLACE HISTORY:

Are you currently employed? ☐ YES ☐ NO (☐ Full-time ☐ Part-time)

- If yes, employer/job description: _____
  Are your symptoms worse at work? _____
- If no, are you: ☐ SAHM/D ☐ Retired ☐ Disabled ☐ Other _____

Are you currently a student? ☐ YES ☐ NO

- If yes, what grade/school? _____
  Are your symptoms worse at school? _____

ENVIRONMENTAL HISTORY:

Describe your home: ☐ House ☐ Condo ☐ Townhome ☐ Apartment ☐ Other
☐ City ☐ Suburbs ☐ Rural area/farmstead ☐ Other
What year was your home built? _____
Describe your HVAC: ☐ Forced air heat ☐ Gas heat ☐ Electric heat ☐ Hot water heat
☐ Wood-burning stove ☐ Kerosene heat ☐ Space heater ☐ Other_____
☐ Central A/C ☐ Window A/C unit(s) ☐ Other_____
☐ No mold/water damage in home ☐ Damp basement at times ☐ Current mold/water - needs remediation