Allergy & Asthma Center of Massachusetts

Allergic and Respiratory Medicine
Adult and Pediatric

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Name (Print) _____ Birth Date _____ Appointment Date _____

SYMPTOMS

Describe your symptoms (check all that apply):

_____

_____

_____

__ Shortness of breath
__ Wheezing
__ Chest Tightness
__ Exercise Limitation
__ Limitation at Rest

__ Chest Pain
__ Hoarseness
__ Throat Irritation
__ Chronic Cough
__ Sleep Disturbance

__ Nasal Congestion
__ Nasal Discharge
__ Post Nasal Discharge
__ Frequent Sneezing
__ Frequent Headaches

__ Eye Redness
__ Eye Itching
__ Eye Swelling
__ Heartburn/Reflux
__ Other _____

__ Skin Itching
__ Skin Dryness
__ Skin Rash

Symptoms (List in order of severity)	Onset Date	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Year Round (YR) No Pattern (NP)
					Trees									
						Grasses								
									Weeds					

Factors which aggravate symptoms (check all that apply) :

__ Seasonal (as above)
__ Exercise
__ Infections

__ Cold Air
__ Heat Humidity
__ Animals

__ Odors/Perfume
__ Smoke
__ Stress

__ Nocturnal/Sleep
__ Heartburn/Reflux
__ Foods

__ Medications
__ Aspirin
__ Other _____

ALLERGIC HISTORY

Have you been evaluated and/or treated for this or other allergic/respiratory conditions in the past?

1. Yourself _____ Dates _____ Over The Counter Medications (OTC) _____

2. Primary Care M.D. _____ Dates _____ Treatment _____

3. Allergists/Other Specialists Date / Allergy Tests/labs/x-rays / Treatment

Allergists/Other Specialists Date	Allergy Tests/labs/x-rays	Treatment
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____
_____	_____ _____	_____

4. What prompted you to seek an allergy evaluation at this time? _____

5. Who suggested that you seek evaluation at this time (self, family, friend, M.D.)? _____

6. How did you hear about us? _____

General Medical History:

OTHER MEDICAL HISTORY (including all non-allergy diagnosis)

Diagnosis	Since	Treatment	Active

IMMUNIZATIONS

Vaccine	Date
Influenza	
Pneumovax	
Hepatitis B	
Tetanus	
PPD	
Other	

PRIOR SURGERY / HOSPITAL / EMERGENCY ROOM VISITS

Diagnosis	Date	Hospital	Treatment

ALLERGIES

	Symptoms
Penicillin	
Aspirin	
Insect Stings	
Foods	

PREVIOUS ALLERGY / ASTHMA MEDICATIONS (Prescription and OTC)

Medicines (Inhalers, Pills, Oral Steroids)	Dose (Sprays, mg)	Times Per Day	Start Date	Stop Date	Effective?

CURRENT MEDICATIONS (List all medications you are presently taking)

Medicines (inhalers, Pills, Oral Steroids)	Dose (Sprays, mg)	Times Per Day	Start Date	Prescribed By

Environmental Survey

RESIDENCE
City_____
House/Apt. _____
Age of Structure _____

Carpets/Rugs
Bedroom _____
Living Room _____

Heating
Forced Air ___
Gas _____
Oil _____
Electric ____
Other _____

Dust Covers
Pillows ____
Mattress ___

Animal Exposure
Cats _____
Dogs _____
Other _____

Air-Conditioning
Central _____
Window _____
None _____

Feathers/Down
Pillows ___
Comforter ___

SMOKING
Cigarettes ____ packs per day
years smoking ___
Start/Stop date ____
Other _____
Smokers at home ____

ALCOHOL USE (drinks per day)
Beer ____ Wine ___
Spirits ___ Other ___

EMPLOYMENT
Occupation _____
Work Environment
-Dust/Smoke _____
-Chemicals _____
-Other Irritants _____
Prior Occupations _____

Family Medical History

List all allergic and non-allergic medical conditions:

Mother _____
_____
Father _____
_____
Siblings _____
_____
Children _____
_____
Other relatives _____
_____

Please bring all of your medications, copies of any prior allergy evaluations, relevant diagnostic tests and this form to your evaluation.
If you have any questions, please call us at (617) 232-1690.

_____ _____

Patient/Guardian Signature **Date**

Daniel G. Steinberg, M.D. **Date**
John L. Ohman, M.D.
Allergy/Clinical Immunology

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