PATIENT INFORMATION

Patient Name:

Last | First | Middle | AKA

Address:

Zip Code: | City: | State:

Home Phone: | Work Phone:

Cell: | Home Fax:

Employer's Name & Address: | SS# - -

Email Address:(will not be shared with outside sources)

Preferred Method of Contact: (circle one) Home # Cell # Work # or Email

Race: | Ethnicity: | Preferred Language:

Date of Birth: | Marital Status: M S D W other | Sex: M F

Primary Care Physician: | Specialist Currently Seeing:

Preferred Pharmacy: | Phone # &/or Location:

How did you hear about us? (please be specific)

Emergency contact/relationship: | Phone:

If the patient is a minor, please fill this section with the parent or legal guardian's information that is bringing patient to appointments

Resp. Party Name:

Last | First | Middle

Address: | Phone:

Date of Birth: | Email: | Sex: (circle one) Male Female

Home Phone: | Work Phone:

Employer's Name & Address:

SS#: - - | Patient's Relationship to Responsible: (circle one) Spouse Child Other

INSURANCE INFORMATION

Primary Insurance Company:

Address: | Phone:

ID# | Insurer/Subscriber Name:

Patient's Relationship to Insured/Subscriber: (circle one) Self Spouse Child Other

Group Name: | Group Number:

Co -Pay Amt $ | Insured's DOB: / / | Group Plan or Private Plan (circle one)

Secondary Insurance Company:

Address: | Phone:

ID#: | Insurer/Subscriber Name:

Patient's Relationship to Insured/Subscriber: (circle one) Self Spouse Child Other

Group Name: | Group Number:

Co -Pay Amt $ | Insured's DOB: / / | Group Plan or Private Plan (circle one)

Advanced Allergy & Asthma Associates/Food Allergy Center of Illinois

Phone 847-888-8802 / Fax 866-246-1164

Health Questionnaire

Name:	Date of Birth:

Referred by?

Reason for seeing allergist, please list symptoms:

How long have you had those symptoms?

Does anything worsen or improve your symptoms (describe)?

Medications and treatments you've tried?

Have you had any Diagnostic tests, labs or pulmonary breathing tests related to these symptoms? If yes, please describe what when & where they were done: _____

Drug Allergy: Name of Drug:_____

What was the reaction?_____

Approximate date of reaction? _____

Current Medications: (list all medications, including those you buy/use without a prescription and any herbal/vitamins suppliments)

	Medication	Dosage	Times per day		**Medication**	Dosage	Times per day
1				6			
2				7			
3				8			
4				9			
5				10			

Do you have a history of? (please circle all applicable)

Allergies affecting (circle one or both) Nose or Eyes Acid Reflux Arrhythmias Asthma Bronchitis Colitis Chemical Dermatitis COPD Coronary Artery Disease Eczema Emphysema Headaches Hives Hypertension Ear Infections Pneumonia Sinusitis Sleep Apnea (CPAP user ?) **Other Medical Issue:**

List other illnesses that you are being treated for: _____

Have you been tested for allergies (when)? _____

Have you been on allergy shots (when & for how long) ? _____

Have you ever had a reaction to foods? If yes, please explain what food and what type of reaction:

_____

Have you ever had a reaction to stinging insect? If yes, please explain what insect and what type of reaction:

_____

Any surgeries or hospitalizations in the past? If yes, what, when & where _____

Pediatric History: (< 10 years) circle applicable

Neonatal : Full term or Premature Complications? Yes or No

Birth: Vaginal or Caesarian Complications? Yes or No

Breast Fed: Yes/No if yes, how long? _____

ALL

Are immunizations up to date? Yes or No If no, please explain

Have you ever had a Pneumococcal vaccination? Yes or No

When was your last influenza vaccine?

Review of Systems	(circle or underline those that are applicable within the last few weeks)
GENERAL:	Anxious, Depressed, Lack of Interest, Sense of Hopelessness, Fatigued, Weight Loss/Gain, Wired
HEAD/NEUROLOGICAL:	Dizziness, Headaches: (Migraines, Tension, Sinus, Undefined) Incoordination, Loss of Sensation/Touch, Memory Loss, Tremors
EYES:	Burning, Dark Circles, Double Vision, Dry, Itching, Pain, Swollen Eyelids, Tearing
EARS:	Itchy, Painful, Popping, Pressure, Ringing
NOSE:	Stuffed/Congested, Clear Discharge, Colored Discharge, Facial Pain, Itchy, Nose Bleeds, Painful, Poor Smell, Post-Nasal Drip, Sneeze, Snorer
MOUTH/THROAT:	Difficult to Swallow, Dry, Bad Taste, Frequent Infections, Hoarseness, Itchy, Bad Breath, Tooth Pain, Mouth-Breather
ENDOCRINE:	Often Cold/Hot, Excessive Sweating, Thyroid Problems, Large Thyroid/Goiter
NECK/HEMATOLOGIC:	Tender Nodes, Unusual Growth, Hemophilia, Bleeding Disorder, Easy Bruising
CARDIOVASCULAR:	Chest Burning, Racing Heart, High Blood Pressure
RESPIRATORY:	Cough, Wheeze, Produce Phlegm, Heavy Feeling, Tight Feeling with Exercise, Shortness of Breath (at Rest or with Exercise)
GASTROINTESTINAL:	Abdominal Pain, Bloating, Change in Appetite, Constipation, Diarrhea, Food Intolerance, Heartburn, Nausea, Vomiting
GENITOURINARY:	Frequent Urination, Burning Urination, Incontinence, Discharge
MUSCULOSKELETAL:	Weakness of Arms or Legs, Sore Joints, Swollen Joints, Back Pain, Gout, Arthritis
SKIN:	Rash, Itching, Swelling, Burning, Dry Skin, Hives

Family History: Do any of your relatives have a history of these? Or **adopted**?	Allergies - Asthma - Colitis - Coronary Artery Disease - Diabetes - Eczema - Emphysema - Food Allergies - Hives - Hypertension - Migraines - Sinusitis - Sleep Apnea - Swelling Disorder - Thyroid Disease - Other:

Social History

Are you exposed to smoke? **Yes** or **No** Who smokes? _____

Are you currently: Smoker? **Yes/No** (if yes answer below)
What year did you begin smoking? _____
How many packs a day? _____

Ex-smoker? **Yes / No** (if yes answer below)
What month & year did you quit smoking? _____
How many years did you smoke? _____

Do you chew Tobacco? Yes or No
What is your occupation and work place? _____
How often do you exercise? _____ Do you use recreational drugs? Yes / No
Do you drink alcohol? **Yes / No** If yes, how often: _____ How much: _____

Environmental History

Do you have pets? Yes/No If yes, what kind and how many of each?

Are you exposed to any other animals on a daily basis? **Yes/No** If yes what kind?_____
Do you use a down or feather comforter or pillow? **Yes/ No** Do you use Dust Mite covers: **Pillows?-Mattress?**
Is there carpeting in your home? **Yes/No** Do you have any mildew/mold in your home? **Yes/No**
Any roaches/rodents? **Yes/No** Approximately, what year was your home/apt built? _____
Any other exposures you feel we may need to be made aware of ? _____