ALLERGY AND ASTHMA INSTITUTE

Adult, Pediatric Allergy & Immunology

Name: ______________________________ **DOB:** ______________

Reason for visit: ______________________________

Previous doctors seen for this problem: ______________________________

My general health is: (please circle): **Poor** **Fair** **Good** **Very Good** **Excellent**

Do you have a history of any of the following:

	YES	NO
Unexplained fevers		
Weight changes		
Headaches (migraines/tension)		
Thyroid disease		
Diabetes		
Changes in vision		
Heart disease / heart attack		
Pacemakers or abnormal heart rhythm		
High blood pressure		
Lung disease (other than asthma)		
Gastrointestinal problems		
Hepatitis		
Urinary problems		
Pain or weakness of extremities		
Memory loss		
Easy bruising/bleeding		
Psoriasis		
Are you pregnant		

For anything answered “YES”, please explain:

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Please list all past surgeries (include dates):

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Please list all medications you are currently taking:

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