ASTHMA AND ALLERGY CARE ASSOCIATES

399 W. Campbell Rd, Suite 308
Richardson, TX 75080

469-330-0800
469-330-0803 fax
richardsonallergy.net

New Patient History

Date:_____

Name _____ If minor, name of guardian_____

Referred by:_____

What is the main reason for your appointment?_____

Please circle all that apply:

Nose:	Itching	Running	Sneezing	Blocking	Nosebleeds
Eyes:	Itching	Watering	Swelling	Redness	Blurring of vision
Ears:	Itching	Blocking	Infections	Ringing	Hearing loss
Throat:	Itching	Voice Loss	Infections	Postnasal Drip	
Chest:	Coughing	Wheezing	Infections	Shortness of Breath	Asthma
Headache:	Sinus	Migraine	Tension	Muscular	Other
Skin:	Hives	Eczema	Itching	Swelling	
Stomach:	Nausea	Heartburn	Indigestion	Diarrhea	Constipation
Other:	Fatigue	Fever	Infections	Loss of weight or appetite	

When did these symptoms occur for the first time in your life?_____

Where were you living then? _____

Are the symptoms you circled All year round OR Seasonal – Spring, Summer, Fall, Winter

Are the symptoms? Mild Moderate Severe

Do the symptoms result in time missed from work/school (if so how much):

_____

Have the symptoms resulted in hospital visits or admissions:

_____

Have you had allergy testing before? If so, when and where?_____

Have you taken allergy shots before? If so, when?_____

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Please list the number of antibiotic prescriptions taken in the past year: _____

Please list any known food allergies:_____ Please list any known medication allergies_____

Please list ALL prescription AND over the counter medications (including supplements, vitamins, etc). Attach a list if preferred. _____
_____
_____
Please list other medical conditions: _____
_____
Please list any surgeries or issues that required hospitalization:_____
_____
Environmental and Social History:
Have you ever smoked cigarettes?____ Cigars? ____Vapor?___ Other?____ Are you still smoking? _____ When did you begin? _____For cigarettes, how many packs per day? _____
How often do you exercise and what forms? _____
Please list all pets:_____
Are you exposed to smoke at home?_____ Do you have carpet in your bedroom?_____
What is your occupation? _____Please indicate if you are exposed to fumes, dust, smoke, chemicals, or other triggers at work _____

Family History:

Condition	**Mother**	**Father**	**Sibling**	**Child**	**Other Family**
Allergic rhinitis					
Asthma					
Eczema					
Thyroid disease					
Migraines					
Heart Disease					
Stroke					
Diabetes					
Cancer					
Arthritis					
Cystic Fibrosis					
Other					