ALLERGIES ANSWERED
ALLERGY · ASTHMA · SINUS

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Patient Information Form

Name: _____ Gender: _____ DOB: _____ Date: _____

Allergies: _____

List ALL MEDICATIONS you take, including OTC (over-the-counter) medications and vitamins. Include specific doses and when taken. If you don't know please contact your pharmacy to confirm. If you need additional space please attach page.

_____
_____
_____
_____
_____
_____

PERSONAL MEDICAL HISTORY: (please circle all that apply)

ADHD	COPD/Emphysema	High Cholesterol	Heart Disease
Eczema	Thyroid disorder	Asthma	Seizure Disorder
Allergies, Seasonal	Depression	Headaches	Sleep Apnea
Arrhythmia	Diabetes: 1 or 2	Hives	High Blood Pressure
Arthritis	GERD (reflux)	DVT (blood clot)	Immune Deficiency
Cancer	Gout	Hepatitis	Glaucoma

Other medical conditions not listed above: _____
_____

SURGICAL HISTORY: (please list all prior surgeries and approximate dates performed)

_____
_____
_____
_____

SOCIAL HISTORY:

Any pets in the home? Yes / No If Yes what types? _____

Do you have a Dust Mite Cover on your mattress? Yes / No

Are your pillows and comforters: Feathered Non-Feathered Unsure?

Do you have Central A/C or Window units? _____

Bedroom Flooring Carpet Tile Laminate Wood Area rugs? Yes / No

Do you smoke? Current Former Never Type: _____

Amount per day: _____ Number of years: _____ Quit date: _____

Do others in home smoke? Yes / No

FAMILY HISTORY:

Father: Living Age_____ Deceased Age_____

Health: _____

Mother: Living Age: _____ Deceased Age: _____

Health: _____

Siblings:_____

_____

_____

Children:

_____

Please list ALL other Medical Providers you see on a regular basis:

_____

_____

_____

_____

_____

_____