



**ALLERGY & ASTHMA FAMILY CARE
OF WESTCHESTER PLLC**

**455 CENTRAL PARK AVENUE, SUITE 207, SCARSDALE, NY 10583
TEL: (914) 574-5720 FAX: (914)574-5723**

MEDICAL HISTORY QUESTIONNAIRE

PATIENT'S NAME: _____ DATE: _____

DATE OF BIRTH: _____ AGE: _____ GENDER: Male Female

REFERRING PHYSICIAN NAME/ADDRESS/PHONE (IF ANY): _____

IF NOT PHYSICIAN REFERRED, HOW DID YOU LOCATE OUR OFFICE? _____

REASON FOR VISIT: _____

CURRENT MEDICATIONS (PLEASE INCLUDE ALL NON-PRESCRIPTION AND PRESCRIPTION PILLS,
CREAMS, LOTIONS, INJECTIONS AND INHALERS): _____

DO YOU HAVE ANY KNOWN ALLERGY TO MEDICATIONS? IF YES, PLEASE INDICATE THE
ASSOCIATED REACTION(S): _____

DO YOU HAVE ANY KNOWN ALLERGY TO FOODS? IF YES, PLEASE INDICATE THE ASSOCIATED REACTION(S): _____

PLEASE INDICATE OTHER KNOWN ALLERGIES IF ANY (EX: INSECT STINGS, LATEX RUBBER, SOAPS/COSMETICS/FABRIC SOFTNERS, VACCINES, PLANTS, MOLD, ETC.) _____

PLEASE LIST ANY KNOWN MEDICAL PROBLEMS (IF ANY): _____

PLEASE LIST ANY PRIOR SURGERIES & MAJOR HOSPITALIZATIONS INCLUDING THE DATE (IF ANY): _____

PAST ALLERGY CARE: PLEASE INDICATE THE NAME, ADDRESS AND PHONE OF THE PHYSICIAN TREATING YOUR KNOWN ALLERGIES: _____

IF YOU HAD SKIN TESTING, PLEASE INDICATE WHEN AND RESULTS (IF KNOWN) _____

IF YOU HAD PREVIOUS IMMUNOTHERAPY (ALLERGY SHOTS), PLEASE INDICATE DURATION OF TREATING, APPROX. DATE OF LAST INJECTION, AND ALLERGENS IN VACCINES (IF KNOWN) _____

ENVIRONMENTAL HISTORY:

TYPE OF HOME: House Co-op /Condo/Apartment Townhouse Other: _____

LENGTH OF OCCUPANCY: _____

TYPE OF HEAT: Baseboard Radiator Force Hot Air Radiant

AIR CONDITIONING: Window Central None

HUMIDIFIER: Individual Unit Central None

DAMPNESS OR MUSTY AREAS: Yes No

UPHOLSTERED FURNITURE: Yes No

BEDROOM: TYPE OF COMFORTER/DUVET: _____

TYPE OF BLANKETS: _____

TYPE OF PILLOWS: Polyester/Cotton Foam Feather/Down

ALLERGY COVERS: Yes No

MATTRESS TYPE: Foam Regular Spring Coil Other: _____

FLOORING (PLEASE SPECIFY WOOD, TILE, LINOLEUM, CARPET, RUG):

LIVING AREAS: _____

BEDROOM: _____

TYPE & NUMBER OF PETS: _____

PREVIOUS PETS: _____

MICE/ROACHES: Yes No OTHER PESTS: _____

FAMILY HISTORY:

HOW MANY SIBLINGS DO YOU HAVE? _____

IF YOU HAVE CHILDREN, HOW MANY MALE & FEMALE? _____

DOES ANY MEMBER OF YOUR FAMILY HAVE THE FOLLOWING: (IF YES, PLEASE INDICATE FATHER, MOTHER, BROTHER, SISTER AND/OR CHILD):

ASTHMA NO YES _____

ECZEMA NO YES _____

HAYFEVER/SINUS NO YES _____

SWELLING NO YES _____

CANCERS NO YES _____

AUTOIMMUNITY NO YES _____

DIABETES NO YES _____

HIGH BLOOD PRESSURE NO YES _____

THYROID DISEASE NO YES _____

STROKES NO YES _____

OTHER: _____

SOCIAL HISTORY:

OCCUPATION: _____

DOES YOUR SYMPTOM(S) WORSEN AT WORK? Yes No

DID YOU EVER SMOKE? Yes No

IF YES, HOW LONG & HOW MUCH? _____

IF YES, ARE YOU STILL SMOKING? Yes No

IF YOU ARE NO LONGER SMOKING, WHEN DID YOU QUIT? _____

DO YOU DRINK ALCOHOL? Yes No

IF YES, WHAT TYPE & QUANTITY AND HOW OFTEN? _____

DO YOU USE RECREATIONAL DRUGS? Yes No

IF YES, WHAT TYPE & QUANTITY AND HOW OFTEN? _____

REVIEW OF SYSTEMS:

DO YOU HAVE PROBLEMS IN THE FOLLOWING?

	YES	NO		YES	NO
SKIN			BONES, JOINTS, MUSCLE		
HEAD,EYES,EARS, NOSE, THROAT			LYMPH NODES		
NECK			INFECTIONS		
LUNGS			ALLERGIC		
HEART, BLOOD VESSELS			IMMUNOLOGIC		
STOMACH, INTESTINES			ENDOCRINE (thyroid, diabetes, etc.)		
KIDNEY, BLADDER			NEUROLOGIC		
GENTIALS			PSYCHIATRIC		
BLEEDING PROBLEMS			OTHER		

IF OTHER, PLEASE SPECIFY: _____

Signature of Patient or Legal Guardian

Print Name of Legal Guardian

Date

Print Name of Patient