(Office Only) MRN: _____

Revere Health Allergy & Immunology

Henry Yeates, MD • Tammy Jacobs, MD
Evangeline Lindorf, NP



**PATIENT NAME:** _____
**DOB:** ____/____/_____ **AGE:** _____ **SEX: M / F**
**Primary Care MD:** _____
**Referring MD:** _____
**Pharmacy (Name/Location):** _____
_____

**Date:** _____/_____/_____
Form completed by: ☐ Patient ☐ Parent/Guardian: _____
**Main Reason for Today's Visit:**
_____

Please also check if you have any of the following conditions:

☐ Allergic Rhinitis/Sinusitis (Hay Fever) ☐ Asthma or Breathing Problems ☐ Food Allergies/Reactions ☐ Eosinophilic Esophagitis
☐ Allergic Conjunctivitis (Eye Allergy) ☐ Hives or Rash ☐ Contact Dermatitis/Rash ☐ Atopic Dermatitis (Eczema)
☐ Allergy/Reaction to Stinging Insects ☐ Allergy/Reaction to Latex ☐ Penicillin Allergy ☐ Frequent Infections

**Medical/Surgical/Hospitalization History:**

☐ Gastroesophageal Reflux (Heart Burn) ☐ High Blood Pressure ☐ Heart Disease ☐ Diabetes
☐ Sleep Apnea ☐ Osteoporosis (or osteopenia) ☐ Thyroid Disease ☐ Cancer, please detail below

Other Diagnosis/Surgery/Hospitalization Date Medications for Medical Condition

_____
_____
_____

**Current Medications (Please Include Name/Dosage/Frequency and Vitamins/Supplements/Over the Counter Medications):**

_____ _____ _____
_____ _____ _____

**Allergy History:**

Medication Allergies Reaction (such as hives, rash, swelling, vomiting, wheezing)

_____ _____
_____ _____

Other (Food, Latex, Stinging Insects) Reaction (such as hives, rash, swelling, vomiting, wheezing)

_____ _____
_____ _____

Immunizations Up To Date: ☐ Yes ☐ No

Influenza Vaccine (this season from September to April): ☐ Yes ☐ No

If you have not received the flu shot this season, would you like it to be administered at this office visit? ☐ Yes ☐ No

**Family History:** ☐ Unknown ☐ Adopted

| | None | Mother | Father | Sibling(s) | Grandparent(s) | Other relative, specify: |
|---|---|---|---|---|---|---|
| Nasal/Sinus Allergies (Seasonal Allergies/Hay Fever) | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Asthma | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Food Allergies | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Atopic Dermatitis (Eczema) | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Bee sting allergy | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Eosinophilic Esophagitis or Trouble Swallowing | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Urticaria or Angioedema (Hives or Swelling) | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Autoimmune Disease (such as Thyroid Disease) | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Immune Problems or Frequent Infections | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Heart Disease | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Stroke | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Lung Disease (such as COPD) | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Diabetes | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Inflammatory Bowel Disease | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Osteoporosis | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Cancer, Type: _____ | ☐ | ☐ | ☐ | ☐ | ☐ | _____ |
| Other Conditions: _____ | | ☐ | ☐ | ☐ | ☐ | _____ |
| _____ | | ☐ | ☐ | ☐ | ☐ | _____ |

TURN PAGE

Revere Health Allergy & Immunology
Henry Yeates, MD • Tammy Jacobs, MD
Evangeline Lindorf, NP

**Social/Environmental History:**

Do you smoke or are you a former smoker? ☐ Yes ☐ No If yes, __ packs per day for __ years. Quit __ years ago.
Do you drink alcohol? ☐ Yes ☐ No
Do you use any drugs/medications recreationally? ☐ Yes ☐ No
Occupation or grade in school: _____ ☐ Homemaker ☐ Unemployed
☐ No Daycare (Stays at Home) ☐ Preschool ☐ Grade School ☐ High School ☐ College
With whom do you (does your child) primarily live: _____ Multiple Households: ☐ Yes
Pets in or around the home: ☐ None ☐ Cat(s) ☐ Dog(s) ☐ Guinea Pig(s) ☐ Bird(s) ☐ Horse(s) ☐ Other: _____
Does anyone inside the home smoke? ☐ Yes ☐ No
Is there any water damage in the home? ☐ Yes ☐ No
Is there any mold inside or outside of your home? ☐ Yes ☐ No
Are there problems with pests inside the home? ☐ Yes ☐ No If yes, specify: _____
What type of heating do you have in your home? ☐ Gas/Forced air ☐ Fireplace/Gas stove ☐ Other: _____
What type of air conditioning do you have? ☐ Swamp cooler ☐ Central air ☐ Window units ☐ None
Do you have carpeting in your home? ☐ Throughout ☐ Minimal ☐ No
Do you use feather blankets or pillows? ☐ Yes ☐ No
Any strong fragrances used in your home? ☐ Yes ☐ No
Do you (does your child) follow a special diet? ☐ Yes ☐ No
If yes, please describe: _____
Have you (or your child) traveled internationally? ☐ Yes ☐ No
If yes, when/where: _____

**Review of Systems:**

Please indicate any symptoms you (or your child) have experienced recently.

Constitutional: ☐ Fever ☐ Chills ☐ Fatigue ☐ Loss of appetite ☐ Weight loss ☐ Weight gain
Skin: ☐ Rash ☐ Itching ☐ Hives ☐ Dryness ☐ Frequent skin infections
Head: ☐ Headache ☐ Sinus pressure ☐ Sinus tenderness
Eyes: ☐ Itchy eyes ☐ Red eyes ☐ Burning eyes ☐ Watery eyes
Ears: ☐ Itchy ears ☐ Frequent ear infections ☐ Ear tubes
Nose: ☐ Itchy nose ☐ Sneezing ☐ Runny nose ☐ Nasal congestion ☐ Frequent sinus infections
Throat: ☐ Heart burn ☐ Difficulty swallowing ☐ Feeling food getting stuck ☐ Painful swallowing
Respiratory: ☐ Cough ☐ Shortness of breath ☐ Wheezing ☐ Chest tightness ☐ Frequent pneumonias
Cardiovascular: ☐ Chest pain ☐ Palpitations ☐ History of fainting
Gastrointestinal: ☐ Nausea ☐ Vomiting ☐ Abdominal pain ☐ Diarrhea Blood in the stool ☐ Constipation ☐ Liver problems
Genitourinary: ☐ Kidney problems ☐ Kidney stones ☐ Frequent infections ☐ Incontinence
Musculoskeletal: ☐ Muscle pain ☐ Joint pain ☐ Joint swelling
Endocrine: ☐ Frequent urination ☐ Thirst ☐ Heat or cold intolerance
Neurological: ☐ Seizures ☐ Learning problems ☐ Migraines ☐ Numbness/tingling in extremities
Psychiatric: ☐ Stress ☐ Depression ☐ Anxiety ☐ Behavioral problems
Other Symptoms: Please List: _____

**Review of Systems Completed:** _____

**Patient Signature**