Allergy and Dermatology Specialists

LONGEVITY PHYSICIAN SPECIALISTS

Allergy Division

Eric Schmitt, MD ● Sarah DeFreitas, PA-C

PATIENT'S INTAKE FORM – CHILD < 14 years old DATE: _____

REASON FOR EVALUATION TODAY? : _____

Describe briefly your most bothersome symptoms, their duration, severity, and previous therapies:

_____

_____

_____

Have you had allergy testing done? ☐No, ☐ Yes If so, **What year, office and doctor**? _____

Have you had allergy shots: ☐No, ☐ Yes. If so, **What time frame**? From _____ to _____

Do you have Asthma? ☐No, ☐Not certain, ☐Yes If so, What year was your last lung function test? _____

ALLERGY TESTING OPTIONS: (Please write your initials, by your choice)

_____I prefer to meet first with a physician to decide what testing, if any, is advised.

_____In order to expedite my allergy evaluation, I prefer to commence with allergy skin prick testing before meeting with my doctor. I have been able to withhold taking any antihistamine medications for the past seven days. Additionally, I understand that the physician may still recommend further testing that may or may not be able to be completed at today's visit.

I am interested in the following for allergy skin testing (please mark any that apply):

☐ Complete Environmental Allergen Panel (designed for consideration for allergy shots)

☐ Complete Food Allergen Panel

☐ Allergen Screening Panel for adults and children

☐ Other allergy testing (Medications, Insects, Venom e.g.) list: _____

ANTIHISTAMINE USE:

☐ Yes, I have been able to withhold all antihistamine medications for the past seven days.

☐ No, I have not been able to withhold all antihistamine medications for the past seven day

☐ I would like to review a list of medications that may interfere with allergy skin testing.

Last time an antihistamine medication taken was? _____

MEDICATIONS: Please list all currently prescribed or over-the-counter Medications/Supplements; **Including any over the counter treatment for HEARTBURN or SLEEP AID.**

Name / Dose / Regimen	Daily	As needed	Name / Dose / Regimen	Daily	As needed

Have you ever been prescribed epinephrine injector? ☐ No, ☐ Yes, in the past, ☐ Currently.

For what reason? _____

Any allergic reactions to medications? ☐No, ☐Yes, if what medication(s) and please describe reaction

_____

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PATIENT'S MEDICAL HISOTRY **(please mark any or all that apply to the following questions)**

Review of System

General: ☐ growth concerns; ☐ weight loss; ☐ weight gain; ☐ fevers; ☐ night sweats; ☐ Other

Head: ☐ headaches; ☐ dizziness; ☐ seizures; ☐ fainting spells; ☐ sinus pain; ☐ Other

Eyes: ☐ redness; ☐ itching / irritation; ☐ dry eyes; ☐ eyelid swelling; ☐conjunctivitis; ☐Eye Pain, ☐Light sensitivity ☐ Acute vision changes, ☐ Other _____

Ears / Nose / Throat: ☐ decreased hearing; ☐ sneezing; ☐ nasal drainage; ☐ nasal congestion; ☐ itching; ☐sinusitis; ☐ nosebleeds; ☐ sore throat; ☐ snoring; ☐ mouth sores; ☐ Nasal sinus polyps ☐ Other _____

Neck: ☐ swollen glands; ☐ thyroid problems; ☐ masses; ☐ Other _____

Heart: ☐ chest pain; ☐ high blood pressure; ☐irregular heartbeats; ☐ Raynaud's; ☐ Other _____

Lungs: ☐ shortness of breath; ☐ chest tightness; ☐ chronic cough; ☐ recurrent pneumonia; ☐Wheezing

GI: ☐ heartburn / GERD; ☐ lactose intolerance; ☐ diarrhea; ☐ vomiting; ☐ abdominal pain; ☐ Other _____

Endocrine: ☐ diabetes; ☐ heat / cold intolerance; ☐ heavy / irregular menstrual periods; ☐ Other _____

Skeletal: ☐ joint pain; ☐ muscle aches; ☐ weakness; ☐ Other _____

Skin: ☐itching; ☐ hives; ☐ rash; ☐eczema; ☐ Other _____

Psychiatric: ☐ depression; ☐ anxiety; ☐ mood swings; ☐ Other _____

Has another physician ever diagnosed patient with:

Asthma?	☐ Yes	☐ No
Nasal Allergies?	☐ Yes	☐ No
Food Allergies?	☐ Yes	☐ No
Hives?	☐ Yes	☐ No
Eczema?	☐ Yes	☐ No
Recurrent Sinus Infections?	☐ Yes	☐ No
Recurrent Ear Infections?	☐ Yes	☐ No
Any other problems:	☐ Yes	☐ No

Has patient ever received the following vaccination:

Seasonal Influenza?	☐ Yes	☐ No
Pneumococcal?	☐ Yes	☐ No

Has patient even had any of the following surgeries:

Sinus Surgery?	☐ Yes	☐ No
Ear tube replacement?	☐ Yes	☐ No
Tonsillectomy?	☐ Yes	☐ No
Adenodectomy?	☐ Yes	☐ No

Has patient ever been hospitalized for:

Asthma?	☐ Yes	☐ No
Allergic Reaction?	☐ Yes	☐ No

Has patient even been seen in ER Dept. or Ugrent Care for:

Asthma?	☐ Yes	☐ No
Allergic Reaction?	☐ Yes	☐ No

Family History

Do any relatives have any of the following (fill in all that apply):

Father:	☐ asthma	☐ nasal allergies	☐ eczema	☐ food allergies	☐ recurrent infections	☐ none
Mother:	☐ asthma	☐ nasal allergies	☐ eczema	☐ food allergies	☐ recurrent infections	☐none
Siblings:	☐ asthma	☐ nasal allergies	☐ eczema	☐ food allergies	☐ recurrent infections	☐ none
Children:	☐ asthma	☐ nasal allergies	☐ eczema	☐ food allergies	☐ recurrent infections	☐ none

Social History

Premature Birth? ☐ Yes ☐ No **Required ICU care as newborn?** ☐ Yes ☐ No

Weight at birth? ☐ + 7 lbs ☐ - 7 lbs **Breastfed?** If yes, how long? _____☐ Yes ☐ No

Antibiotic use under 12 mos of age? ☐ Yes ☐ No **if yes** ☐ less than 3 times ☐ more than 3 times

School/Day care? ☐ Yes ☐ No **if yes** ☐ Part time ☐ Full time

Suspected mold or known water damage in home? ☐ Yes ☐ No **Pets?** ☐Yes ☐ No

Air purifier use? ☐ Yes ☐ No **Additional physical activity?** ☐ Yes ☐ No

FOR OFFICE USE ONLY Height: Weight: Temperature: BP: Pulse: