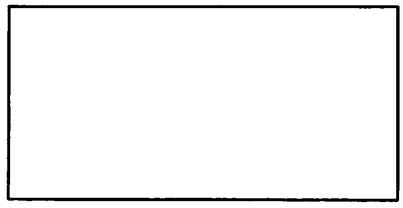
MGH Allergy Associates

Patient Information



(Please fill out all forms completely prior to your appointment or <u>it may delay you being seen by the physician.</u>) *If you need a language interpreter to fill out the forms please arrive 30 minutes before your scheduled appointment and request an interpreter.*

Patient's Name _____ date of birth ____/____/_____

<u>Local</u> Pharmacy Name and Phone Number _____
Pharmacy address (street and city) _____

<u>Mail</u> Order Pharmacy Name and Phone Number _____
Pharmacy address (street and city) _____

Who referred you to Allergy Associate?
_____ Referred by physician (list name of referring MD) _____
_____ Other (please describe) _____

In order to send written reports to your health care providers, or to discuss your case with them, we need your permission. Please list here all doctors with whom you would like us to correspond. **If you do not want reports sent to any providers, please list this clearly in writing.**

Primary care provider name _____
Address _____
_____
Phone number of PCP _____ Fax number of PCP _____

Other health care providers whom reports should be sent:

Name _____ Name _____
Specialty _____ Specialty _____
Address _____ Address _____
_____ _____
Phone _____ Phone _____

☐ Please check box if you are interested in being contacted about research studies which may be related to your health problem.

Patient signature _____ Date ____/____/____

MGH Allergy Associates Patient Information
Please complete <u>both</u> sides of this form before you arrive for your first visit. You cannot see the doctor until the forms are completely filled out.

Name: _____ Date of birth ____/____/____ Today's date___/___/___

Check the box that states the <u>main</u> reason for your visit.
□ Nasal allergy symptoms □ Asthma □ Sinus problem □ Food allergy
□ Medication allergy □ Hives and/ or swelling □ recurrent infections
□ Others: (Please list) _____

Home environment
Please check <u>all</u> the boxes that describe your environment.
□ feather pillows □ down comforter □ carpet on bedroom floor
□ dust proof mattress cover
Type of mattress: □ box spring/regular □ water □ foam □ other _____
□ Cat(s) □ Dog(s) □ Cat or Dog go into the bedroom
□ other pets (list) _____
Air conditioning □ none □ Central □ Window
Humidifier □ none □ Central □ single room unit
Type of heating □ Forced hot water □ Forced hot air □ electric baseboard
□ Visible mold, mildew or dampness in your home Location _____
□ Evidence of cockroaches

Work environment
□ Office □ Other, please describe _____
□ Old □ Dusty □ damp □ Visible mold
List other features in your work environment that you feel are contributing to your problem _____

List medications, vitamins and herbal supplements you are taking. Include <u>all</u> prescriptions and over the counter medications.

drug name/dose/frequency	drug name/dose/frequency

List all medication allergies

Drug name	Type of allergic reaction	Estimate of date of occurrence

Family History

	Asthma	Hay fever	Eczema	Hives	Swelling	Food Allergy
mother						
father						
brother/sister						
children						
other						

Social History
Occupation_____ How long? _____yrs. Hobbies_____
□ Smoking history Age that you started _____ Age Quit _____ packs per day___

Physician Notes

Patient Name: _____

Review of Symptoms

Please put a check the appropriate box.

General	Yes	No	Neck	Yes	No
Recurrent fever			Swelling		
Large weight loss/gain			Lumps		
Difficulty sleeping			Other _____		
Other _____			**Skin**		
Eyes			Changing mole		
Blurred vision			Rashes		
Light flashes			Bruises easily		
Pain in eyes			Other _____		
Other _____			**Endocrine**		
Ears/Nose/Throat			Constant thirst		
Hearing difficulty			Too warm, too cold		
Nose bleeds			Jumpy/nervous		
Sinus trouble			Other _____		
Ear Pain/popping			**Bone/joints**		
Other: _____			Painful joints		
Cardiovascular			Swollen joints		
Fluttering heart			Muscle pain/tenderness		
Unusual heartbeat			Other _____		
Chest pain			**Neuromuscular**		
Swollen ankles			Weakness in arm/leg		
High Blood pressure			Difficulty with balance		
Other _____			Dizzy, fainting spells		
Respiratory			History of seizure		
Shortness of breath			Other _____		
Poor exercise tolerance			**Psychological**		
Persistent cough			Do you find life		
wheezing			Unsatisfactory		
Other _____			Too demanding		
Genitourinary			Boring		
Blood in urine			Satisfactory		
Pain/burning on urination			Do you		
Up at night to urinate			Cry easily		
Kidney Stones			Fell depressed		
Problems with periods (women)			Have many fears		
Other _____			Feel anxious		
diarrhea			**Pain**		
Black, tar-like stools			Is your pain caused by allergies?		
Other _____			If *no*, do not continue any further with questionnaire.		
			If *yes*, state the location of your pain _____		
			_____		

Circle number on pain scale that best reflects your pain caused by allergy

No Pain **Quite a lot of Pain** **worst pain imaginable**

0 1 2 3 4 5 6 7 8 9 10

Reviewed by _____ Date ____/____/_____