Kern Allergy Medical Clinic

Patient Name: _____

Primary doctor: _____

Referring doctor: _____

New Patient Health History Form

Your answers on this form will help your health care provider better understand your medical concerns and conditions. Please take time to complete this questionnaire before your appointment. **Thank you!**

Main reason for today's visit:

_____

PATIENT HEALTH HISTORY: Please check or circle any CURRENT diagnosed medical conditions

___ Asthma
___ Arthritis / Rheumatoid Arthritis_____
___ Angioedema
___ Autoimmune Disorder / Lupus / Epstein Barr / CVID
___ Infectious Disease (HIV/TB)
___ COPD
___ Cancer, if yes please specify which type: _____
___ Crohn's Disease
___ Diabetes if yes please specify which type: _____
___ Fibromyalgia / Multiple Sclerosis
___ Neurological Disorder / Seizures
___ Psychological/Mental Disorder / Depression / Anxiety / Other: _____
___ Hypertension
___ Hypothyroidism
___ High Cholesterol
___ Heart Disease
___ Gastrointestinal Disorder, Heartburn or Indigestion
___ Kidney disease
___ Osteoporosis
___ Urticaria / Dermatitis / Eczema

Are you currently pregnant or expect to become pregnant? Yes___ No___

What medications are you currently taking? (Include over-the-counter products, vitamins, and herbal remedies)

_____ _____
_____ _____
_____ _____

Have you been hospitalized? Please list approximate dates and reasons:

_____ _____
_____

Have you had surgery? Please list approximate dates and reasons:

_____ _____
_____

Do you have any medication allergies? Yes ____ No ___
If YES please list:

_____

IMMUNIZATIONS:
Did you have the influenza vaccine this season? Yes ___ No ___

(OVER)

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FAMILY HISTORY (Please indicate family members with any of the following conditions):

	Mother	Father	Sibling
Hereditary Angioedema	☐	☐	☐
Hay fever	☐	☐	☐
Urticaria/Dermatitis	☐	☐	☐
Dermatographism	☐	☐	☐
Asthma	☐	☐	☐
Allergies to food	☐	☐	☐
Immunologic disorder	☐	☐	☐
Respiratory diseases	☐	☐	☐
Melanoma	☐	☐	☐
Heart Disease	☐	☐	☐
Cancer	☐	☐	☐
Thyroid Disease	☐	☐	☐
Diabetes	☐	☐	☐
High blood pressure	☐	☐	☐
Other _____	☐	☐	☐

ENVIRONMENT/SOCIAL HISTORY:

Do you have pets at home? Yes ___ No ___ What type of flooring is in the home? Circle all that apply
Carpet Tile Laminate Wood Other: _____

If YES, please circle: Cat Dog Bird Other please clarify if pet(s) are in/outdoor or both:

_____

Do you have an A/C or swamp cooler in the home? _____

Do you participate in sports/outdoor activities? _____ If yes, please indicate: _____

SMOKING HISTORY

- Do you smoke? Yes ___ No ___ Have you ever smoked? Yes ___ No ___ Quit Date: _____
- How many packs per day? _____ # of years _____
- Are there any smokers living in the home? Yes ___ No ___

Have you had previous allergy testing done thru lab work or skin test? If so please list when and where testing was performed (ex; Quest Diagnostics, PAL, Foundation Lab, LabCorp or doctor's office):

_____

WORKPLACE ENVIORNMENT:

Do you work in/outdoors? _____ Occupation: _____

FOR WOMEN ONLY:

_____

When was your last Pap smear? (Please list approximate date done- if you've had a Hysterectomy list date of surgery)

_____

When was your last Mammogram? (Please list approximate date done)

_____

When was your last Colonoscopy? (Please list approximate date done)

FOR MEN ONLY:

_____

When was your last Colonoscopy? (Please list approximate date done)

In Office Use Only – Reviewed by: _____