THE Woodlands Allergy
ASTHMA & IMMUNOLOGY CENTER

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ADULT ALLERGY INTAKE FORM

Patient Name: _____ DOB: _____ Today's Date: _____

Primary Care Provider: _____ Referred by: _____

Preferred LOCAL pharmacy (name and location): _____
Preferred MAIL-ORDER pharmacy (name): _____

Email: _____ □ prefer not to provide

MEDICATIONS and **SUPPLEMENTS** currently taken: □ NONE □ See attached page

DRUG ALLERGIES: □ No known drug allergies

Stinging Insect Allergies: □ No known insect allergies

□ Bee □ Wasp □ Yellow Jacket □ Hornet □ Fire Ant REACTION: _____

Food Allergies (specify food and reaction): □ No known food allergies

_____

REASON FOR VISIT: (check all that apply)

□ Nasal or Sinus Problems □ Skin Rash/Hives □ Drug allergies

□ Chest Problems □ Food Allergies □ Insect stings

□ Frequent infections □ Other: _____

HAVE YOU BEEN SKIN TESTED BEFORE? □ Yes □ No Date: _____ Results: _____
Have you been on allergy shots/drops before? □ Yes □ No Date: _____ Effectiveness: _____

Name: _____ DOB: _____ Date: _____

ALLERGY, ASTHMA & IMMUNOLOGY PERTINENT HISTORY:

□ Emergency Room Visits: (per month/year) _____ Reason: _____
□ Hospitalizations: (per month/year) _____ Reason: _____
(for asthma, COPD, allergies, swelling, or infections only)

How long have you lived in Central Texas: _____
Where else did you live before: _____

Home Environment: □ House □ Condo □ Apartment □ Modular home **Years lived there**: _____
Age of home: _____ □ Air conditioning □ Forced air heat □ Carpeting in the bedroom
□ Down bedding □ Dust mite covers □ Dusty hobbies □ Animals in the home (type) _____

PAST MEDICAL & SURGICAL HISTORY (mark all that apply):

Skin: □ eczema □ hives □ swelling □ contact dermatitis □ mastocytosis □ other _____

Head, Eyes, Ears, Nose, Throat: □ chronic ear infections □ frequent sinus infections □ nasal polyps
□ deviated nasal septum □ nasal fracture □ tonsillitis □ glaucoma □ contact lenses

Chest: □ asthma □ COPD □ chronic cough □ tuberculosis □ cystic fibrosis □ sleep apnea
If YES to asthma - common triggers include: □ infections □ exercise □ allergies □ cold air □ smoke

Immune Function: □ seasonal allergies □ pet allergies □ frequent bronchitis □ recurrent pneumonia
□ hypogammaglobulinemia □ other immune disorder _____

Other Medical history: □ thyroid disease □ heart disease □ high blood pressure □ diabetes □ depression
□ cancer (type: _____) □ autoimmune disease (type:_____)

Relevant surgeries: □ Tonsillectomy (year: _____) □ Adenoidectomy (year: _____)
□ Nasal/sinus surgery (year: _____ reasons: _____)

FAMILY HISTORY *of allergies, asthma or immune problems only:*

SOCIAL HISTORY:
Marital status _____ Occupation: _____ Employer: _____

LIFESTYLE:
Exercise: □ sedentary □ moderate □ vigorous Type: _____ Hours per week: _____
Smoking status: □ current □ former □ never
Tobacco use (past or present): Type:_____ Amount: _____ Year of use: _____
Secondhand smoke exposure: Smokers in the home □ Yes □ No

HEALTH MAINTENANCE:
Vaccines: □ Flu (year_____) □ Pneumonia (year_____) □ Pertussis (year_____)

THANK YOU!