



Patient Screening Form

Date: _____ Patient's Name: _____ Age: _____

Patient's Primary MD: _____ Practice Type: GP FP Internist Peds
Other: _____

Who referred you to this clinic? Self-referred Primary MD Other: _____

Patient's symptoms: (check all that applies):

- | | | | |
|---|------------------------|--|------------------------|
| <input type="checkbox"/> Eye symptoms | Age when started _____ | <input type="checkbox"/> Asthma/Wheezing | Age when started _____ |
| <input type="checkbox"/> Nose symptoms | Age when started _____ | <input type="checkbox"/> Hives or Swelling of skin | Age when started _____ |
| <input type="checkbox"/> Snoring | Age when started _____ | <input type="checkbox"/> Persistent Rash or Eczema | Age when started _____ |
| <input type="checkbox"/> Sinus symptoms | Age when started _____ | <input type="checkbox"/> Food Reactions | Age when started _____ |
| <input type="checkbox"/> Cough | Age when started _____ | <input type="checkbox"/> Drug Allergy | Age when started _____ |
| <input type="checkbox"/> Acid Reflux | Age when started _____ | <input type="checkbox"/> Insect Sting Allergy | Age when started _____ |
| <input type="checkbox"/> Difficulty breathing | Age when started _____ | | |
| <input type="checkbox"/> Recurring infections | Age when started _____ | | |
| <input type="checkbox"/> Other problems: | _____ | | |

Environmental triggers:

- | | |
|----------------------------------|--|
| <input type="checkbox"/> Trees | <input type="checkbox"/> Being Indoors |
| <input type="checkbox"/> Grasses | <input type="checkbox"/> Being Outdoors |
| <input type="checkbox"/> Weeds | <input type="checkbox"/> School |
| <input type="checkbox"/> Molds | <input type="checkbox"/> Workplace |
| <input type="checkbox"/> Dogs | <input type="checkbox"/> Strong Odors |
| <input type="checkbox"/> Cats | <input type="checkbox"/> Weather Changes |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Strong Emotions |

When are symptoms the most severe?

- | | |
|-----------------------------------|------------------------------------|
| <input type="checkbox"/> Spring | <input type="checkbox"/> Morning |
| <input type="checkbox"/> Summer | <input type="checkbox"/> Afternoon |
| <input type="checkbox"/> Fall | <input type="checkbox"/> Evening |
| <input type="checkbox"/> Winter | <input type="checkbox"/> Night |
| <input type="checkbox"/> All Year | <input type="checkbox"/> All Day |

Previous Allergy History

Has the patient ever been tested for allergies in the past? **Yes** **No** If "Yes" when? _____

Main Office:
Medical Center
2414 Babcock Rd. Ste 109
San Antonio, TX 78229

Southside:
SW Medical Bldg.
7500 Barlike Blvd. Ste 106
San Antonio, TX 78224

Stone Oak:
Physician Plaza 1
19016 Stone Oak Pkwy. Ste 250
San Antonio, TX 78258

T: 210-616-0882
F: 210-692-7833
allergysta.com
revised 03/24/2015

Has the patient ever been on allergy shots in the past? **Yes** **No** If "Yes" when? _____

Asthma History

Have you ever been intubated, placed in intensive care, or on a respirator for asthma? _____

Number of hospitalizations for asthma: _____

Number of emergency room visits for asthma in the last year: _____

Medications:

Current medications: _____

Please List Others:

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Antibiotics in the past 6 months: _____

Steroids (injection or oral) in the past 6 months: _____

Medication Allergies: _____

Please list any ENT surgeries the patient has had and indicate their age at the time:

Please list any significant injuries the patient has had to their head or chest (eg., broken nose, etc):

Family History

Does anyone in **the patient's** immediate family have any of the following problems?

	Nasal allergies	Sinus problems	Asthma	Food allergies	Skin allergies
Patient's Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient's Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Brothers/sisters	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Patient's Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History

If the patient is a minor, who has custody? _____

Who does the patient live with? _____

Do you smoke tobacco products?

Current Smoker - Everyday, Packs per day _____, Number of Years _____

Former Smoker, Quit in year _____, Packs per day _____, Number of Years _____

Never Smoked

Are there smokers in the home? Yes No Who? _____

Alcohol use: Yes _____ No _____ Socially _____ Never _____

Do you live in a house or apartment?

How old is the home? _____ How long have you lived in the home? _____

Does the home have mold or has had mold problems? _____

Is there carpet in the house? Yes No How old is the carpet in the home? _____

Indoor pets? Yes No

Who lives in the home with the patient? _____

Any family members attend day care? _____

What is your occupation? _____

Is the patient exposed to any of the following?

Fireplace Wood-burning stove Strong fumes/chemicals Pollution

Dietary History:

Are there any foods that cause you an allergic reaction?

Food

Reaction

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

All 3 pages reviewed by provider: _____ Date: _____