

In an effort to know as much as we can about you to assist with your visit with the Allergist/Immunologist, please complete the following two pages. When form is fully completed, please save the file and forward the attachment via email to: allergy@cooperhealth.edu prior to your appointment, or print and bring with you if that is easier. **Thank you!**

Patient Name: _____ Date of Birth: _____

MUST FILL OUT. PLEASE TELL US THE REASON YOU ARE HERE TODAY:

I am here TODAY because: _____

Are you currently pregnant? check if YES (we cannot perform a skin test if you are pregnant)

PAST Medical History

Have you ever seen a health care provider for any of the following: (please check box if YES)

- | | | | |
|--------------------------------------|---|---------------------------------------|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Hives | <input type="checkbox"/> Swelling |
| <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Ear infections | <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Year-round allergies |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Eczema | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Seasonal allergies (spring/fall) |
| <input type="checkbox"/> Other _____ | | | |

Hospitalizations: _____

Surgical History: _____

Previous Allergy Testing or Lab Tests? Yes: approximately what year? _____ No

Previous Chest X-ray? Yes: approximately what year? _____ No

Diet: Are you able to eat the following foods?: (please check the boxes)

- YES, I CAN eat: Milk Eggs Peanut Tree nuts (all other nuts) Shellfish Fish

Present Medications: _____

Immunizations: Have you had the following Immunizations?: (please check the boxes)

- Pneumovax/Prevnar (pneumonia vaccine) Varivax (chickenpox vaccine) Flu vaccine COVID Tdap

Drug Allergies: _____ **Food Allergies:** _____

Latex Allergy: (any problems with balloons or dental procedures, etc.) _____

Insect Sensitivity: (bee, wasp, hornet, spider, mosquito) Never stung Stung – No reaction Stung with reaction

Reaction: Small swelling at site Large swelling at site Hives; swelling of the lips, tongue, throat; trouble breathing

Contrast Dye Allergy: (MRI or CT scan) No exposure Exposed (no reaction) Exposed (with reaction)

Family History: Does anyone in the family have the following? (place an X if YES)

	Asthma	Allergic rhinitis (hayfever/seasonal allergies)	Sinus problems	Food allergy	Eczema (skin problems)	Drug allergy	Other
Mother							
Father							
Siblings							

Social history: I am: (please check box) Married Divorced Single Partnered

My home is: Single family Apartment Condo/townhouse Other _____

My neighborhood is: Urban Suburban Farm Woods Lake Coastal

Problems in the home with: Mice/rats Cockroaches

Basement: Do you have a basement? Yes No **If YES, is it** Dry Damp

Type of heat in your home:

Gas/FHA Oil Electric Kerosene Radiator Baseboard Fireplace Wood-burning stove

In winter, we keep our home thermostat at: 70° Less than 70° Greater than 70°

Your bedroom floor has: Wall-to-wall carpeting Hardwood Area rug Linoleum

Bed: Regular bed Other _____

Pillow: Fiber filled Feather Foam

Pillow cover (hypoallergenic): Yes No

Mattress cover (hypoallergenic): Yes No

Occupation: _____ **Student studying:** _____

Smoking/vaping: Does anyone smoke or vape in the house? Yes No

Patient, If yes: _____ #packs per day _____ #years

Did you quit smoking? **If so, how many years ago?** _____

Pets: None Dog(s) _____ Cat(s) _____ Bird(s) _____ Other _____

Skin Care: For eczema, dry skin, or other skin conditions

Type of soap or skin wash: _____

Type of moisturizers: _____

Laundry detergent: _____ **Dryer sheets** Yes No **Fabric softener** Yes No

Skin medications: _____

If you are seeing us due to a reaction of any kind (hives, swelling, itching, etc.) to a food/drug/any other substance, please provide any pertinent information that may be helpful for the physician to determine what may have caused the reaction. For example: Foods eaten 24 hours prior to a reaction, medications, lotions, soaps, laundry detergents, pets, or outdoor allergens. Please keep in mind that if you had a reaction to a drug, we may not be able to test the specific drug. Your evaluation is of the utmost importance to us, and we will strive to find answers for you.



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