ADULT

Allergy & Immunology New Patient Form

(over 3 years since last seen = NEW Patient) **PAGE 1 OF 2**

Cooper University Health Care

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!***

Date of Appointment: ______________________________

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)*

❏ Asthma ❏ Sinus problems ❏ Hives ❏ Swelling
❏ Bronchitis ❏ Ear infections ❏ Hearing loss ❏ Year-round allergies
❏ Pneumonia ❏ Eczema ❏ Acid reflux ❏ Seasonal allergies (spring/fall)
❏ 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							

Please complete both sides

Allergy & Immunology New Patient Form

(over 3 years since last seen = NEW Patient)

Cooper University Health Care

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.

Once this 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.

Please complete both sides