*Allergy & Asthma Centers Of RI*
Dr. Russell Settipane
Dr. Robert Settipane
Dr. Alan Gaines
*All Board Certified Allergists*
Telephone (401)331-8426

# Initial Allergy History

**Date**: _____
**Name:** _____
**DOB:** _____

**Were you referred by another Doctor , NP, or PA?** ☐ **Yes** ☐ **No**

**Referred By:** _____

**ALL PATIENTS PLEASE FILL OUT SECTION A, PAGES 1-3, THEN FILL OUT SECTION B OR C IF APPLICABLE.**

**A. General – check all that apply**

☐ Stuffy or runny nose, sneezing, post-nasal drip, sinus or eye problems (Please also fill out section B)

☐ Asthma, wheezing, shortness of breath, cough, chest congestion (Please also fill out section C)

☐ Reaction to stinging insects

☐ Eczema/dermatitis/skin rashes

☐ Hives, angioedema, swelling, urticaria

☐ Possible allergies to drugs/medications/shots

☐ Possible allergies to foods

☐ Other (specify)_____

**Please state why you are here and what it is that you desire to result from today's visit:**

_____

_____

P**lease List Current Medicines**- include all prescription and over-the-counter drugs you take, including eye drops, nose sprays, vitamins, birth control pills, etc.

| Name of Medicine | Amount (mg., puffs, etc.) | Times/Day | Check one | |
|---|---|---|---|---|
| | | | Every Day | As Needed |
| | | | | |
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**Past Medical History:**

Other Chronic Conditions — Age or Year

_____ since _____
_____ since _____
_____ since _____

Hospitalizations:

Approx Year

_____ for _____
_____ for _____

Emergency Visits:

_____ times in the past year
_____ times in the past 5 years

**Drug/ medication allergies**: **Symptom** **When reaction happened**

_____ caused _____ _____ years ago
_____ caused _____ _____ years ago
_____ caused _____ _____ years ago

**Previous allergy testing:**

Tested by _____ Date: _____

Testing positive for _____

Received shots: ☐ No ☐Yes From Year_____ to Year_____

If yes, then the shots helped: ☐ a lot ☐ somewhat ☐ a little ☐ not at all

If yes, did you have any bad reactions to the shots? ☐ No ☐ Yes (Describe) _____

_____

_____

**Review of systems:**

Yes No

☐ ☐ Fever, weight loss, fatigue_____
☐ ☐ Problems, with eyes _____
☐ ☐ Problems with ears, nose, mouth, throat _____
☐ ☐ Heart problems or high blood pressure _____
☐ ☐ Lung problems ( other that asthma)_____
☐ ☐ Stomach upset/ reflux/ bowel problems_____
☐ ☐ Bladder, urinary, or kidney problems _____
☐ ☐ Joint swelling or pain _____
☐ ☐ Skin problems / rashes _____
☐ ☐ Depression or other pyschiatric problems _____
☐ ☐ Migraines or neurological problems _____
☐ ☐ Problems with thyroid, diabetes, other endocrine_____
☐ ☐ Problems with blood counts, anemia, cancer _____

**Immunizations:** Year

Covid 19 vaccines (all dates) _____
Influenza vaccine (most recent) _____
Pneumococcal vaccine _____
Tuberculosis test _____

**Family History**

Which of your blood relatives have (or have had) the following problems:

Asthma _____ Migraines_____
Hay fever / sinus problems _____ Tuberculosis_____
Eczema_____ Other_____
Hives/swelling_____

**Social History**

What type of work / school do you currently do? _____
What fumes / chemicals / etc. are you exposed to? _____
Are symptoms worse at work? _____

Are you a smoker? ☐ Yes ____ PPD for ____ years
☐ Quit ____years ago after smoking ___ ppd for ___years
☐ No

**Environmental Hx:**

Bedroom:

☐ feathers/down pillow or comforter ☐ rugs ☐ wall to wall carpeting
☐ air conditioner ☐ air cleaner ☐ humidifier
☐ dehumidifier

House:

☐ cats for ___ years ☐ dogs for ___ years ☐ other (_____) for ___ years
☐ smokers in house ☐ wood stove used ☐ problems with mold/mildew
How old is house? _____ How many years in this house? _____
What type of heat? __ hot air/vents __ hot water/baseboard __ steam radiators
__ electric heat __ space heaters

## B: Nose/Sinus/Eye problems (if applicable)

Check all that apply:

☐ stuffy nose ☐ post- nasal drip ☐ sneezing ☐ itchy eyes ☐ itchy nose, ears, palate
☐ sinus pressure/pain ☐ headaches ☐ runny nose ☐ watery eyes

Symptoms have been present for _____ years/months

Symptoms occur: ___year round
___year round, but worse in: ☐ spring ☐ summer ☐ fall ☐ winter
___only in ☐ spring ☐ summer ☐ fall ☐ winter

Symptoms are worse: ☐ at home ☐ at work ☐ indoors ☐ outdoors ☐ in morning ☐ at night

Symptoms worse near: ☐ animals (_____) ☐ dust ☐ fresh cut grass
☐ damp weather ☐ cold ☐ warm dry air
☐ smoke ☐ perfumes ☐ detergents
☐ food (_____) ☐ anxiety ☐ other _____

Medicines that have helped: _____

Medicines you have tried that have **not** helped _____

Any history of : ☐ broken nose ☐ deviated septum ☐ nasal polyps ☐ sinus surgery?

## C: ASTHMA/BREATHING PROBLEMS (if applicable)

When did you start having this type of problem?_____

How often do you now have symptoms of cough, wheeze, or shortness of breath?

□2 days/week or less □3-6 days/week □nearly every day

How often do you have problems sleeping or wake during the night because of asthma?

□ 2 nights/month or less □3-4 nights/month □more than once/week

How much work/school have you missed due to asthma in the last 6 months? _____

What triggers your asthma?

□ catching a cold □ strenuous exercise □ mild exercise
□ cold weather □ damp weather □ air conditioning
□ smoke □ fumes □ stress/anxiety
□ dust □ pollen □ animals (_____)
□ aspirin □ other medicines (_____) □ beer/wine
□ other foods (_____) □ other (_____)

What medicines for asthma do you take every day? _____

What medicines for asthma do you take only as needed? _____
How often do you need this? _____Times per: (Circle One) Day Week Month

Do you have a spacer for your inhalers? _____

Do you have a peak flow meter at home? □ yes □ no

If yes, what is your personal best peak flow? _____ What have recent peak flows been? _____