HEAL
Hudson-Essex Allergy

Please complete this page and return it to the front desk before completing the rest

PATIENT INFORMATION **DATE**_____

Patient's Name_____ Date of Birth_____
Last *First*

Address_____ Sex _____

City_____State_____ Zip Code _____ Home Phone_____

Email _____ Cell Phone_____

Race: ☐ Caucasian ☐ Black or African American ☐ Asian ☐ Declined to report

Ethnicity: ☐ Hispanic/Latino ☐ Non-Hispanic or Latino ☐ Declined to report

Language Spoken _____ Marital Status: S M W D SEP (Circle One)

Emergency Contact_____ Relationship_____

Home Phone_____ Cell Phone_____ Work Phone_____

PRIMARY CARE PHYSICIAN/PHARMACY

Doctor's Name_____ Name of Practice_____

Address_____ Phone Number_____

Pharmacy Name _____ Phone Number_____

Address_____

RESPONSIBLE PARTY/POLICY HOLDER INFORMATION

Name_____ Relationship_____ DOB_____

Address_____ City_____ State _____Zip_____ Phone Number_____

INSURANCE ***(SKIP THIS SECTION IF YOU HAVE YOUR INSURANCE AND PHARMACY CARDS WITH YOU TODAY)***

Primary Company_____ Secondary_____

ID Number_____ ID Number_____

Group Number_____ Group Number_____

Subscriber_____ Subscriber_____

Co-Pay $_____Effective Date_____ Co-Pay $_____Effective Date_____

Referral Required YES NO Referral Required YES NO

Rx Insurance Card:_____ RxBIN:_____

RxPCN:_____ RxGRP:_____

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Allergy History Form

Date:_____

Name of Patient: _____ Age: _____

Referred By: _____ Primary Physician: _____

What is the Major Reason(s) for Allergy Consultation:

_____

_____

_____

Nasal and Eye Symptoms:

□ None □ Nasal Blockage □ Sneezing □ Post Nasal Drip □ Itchy Nose
□ Itchy Eyes □ Sinus Pain □ Ear Problems □ Other: _____

Allergy Medications Taken: _____

Skin Problems:

□ None □ Eczema □ Hives □ Rash □ Other: _____

Asthma and Cough:

□ None □ Asthma □ Cough □ Shortness of Breath
Triggers: □ Colds □ Allergies □ Exercise □ Other: _____

Inhaler Medications Taken: _____

Food Allergies *(Please List)*: _____

Medication Allergies *(Please List):* _____

Reactions to Bee/Insect Stings *(Please List):* _____

Disorders of the Immune System *(Please List):* _____

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Family History:

Father	□ Asthma	□ Seasonal Allergies	□ Skin Allergy	□ Other:
Mother	□ Asthma	□ Seasonal Allergies	□ Skin Allergy	□ Other:
Brother(s)	□ Asthma	□ Seasonal Allergies	□ Skin Allergy	□ Other:
Sister(s)	□ Asthma	□ Seasonal Allergies	□ Skin Allergy	□ Other:
Child(ren)	□ Asthma	□ Seasonal Allergies	□ Skin Allergy	□ Other:

Environmental History:

List **ALL PETS** in the home: _____

BEDROOM: Winter bedroom temperature: _____

FLOOR COVERING: ϒ Wall to wall carpet ϒ Area rug ϒ Wood floor ϒ Carpet over cement

HEATING SYSTEM: ϒ Forced hot air ϒ Electric baseboard ϒ Hot water baseboard ϒ Wood burning stove ϒ Other:

AIR CONDITIONING: ϒ None ϒ Window ϒ Central

BASEMENT:

ϒ None ϒ Finished ϒ Unfinished ϒ History of water leakage

Please describe the **TYPE OF WORK** or **DAILY ACTIVITY**:

ϒ Office setting ϒ Outdoors setting ϒ Homemaker ϒ School (grade:)

Please note any other history that you feel the doctor should know about you. If appropriate, note any stress or emotional problems that might affect your symptoms:

_____
_____
_____
_____
_____

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