Allergy & Asthma Care of Rockland, P.C. Food Allergy Treatment Center Medical History Form

Patient Name: _____ Sex: ___ DOB: ___/___/___

Do you see an allergist: Circle YES or NO	Primary Care Doctor:
Name:	Name:
Address:	Address:
Most Recent Visit:	

Allergy History: Please list foods you are allergic to:

_____

Have you/your child ever had an allergic reaction? Circle: **YES** or **NO**

If yes, to what food/foods? _____

Please describe reaction/reactions:

_____

_____

Date of reaction/reactions: _____

Treatment Given: _____

How much allergen was eaten? _____

Skin tested to allergen? Circle: **YES** or **NO** Date: _____ Result: _____

Date of most recent blood test: _____ Result (if known): _____

Oral Challenge? Circle: **YES** or **NO** Result: _____

Allergy History: (Symptoms, triggers, current treatment , date of onset/diagnosis)

All food allergies/ to what _____

_____

Asthma: _____

Allergic Rhinitis: _____

Atopic Dermatitis (Eczema): _____

Drug/ Insect Allergy: _____

Please circle which medication used: **EpiPen/ EpiPen Jr. Auvi-Q/ Auvi-Q Jr.**

Date expires: _____ (if expired, please ask for a prescription)

Significant Medical History: _____

_____

_____

Family history of allergy (Immediate family members): _____

_____

All Current Medications:

Medication	Dose	Indication

If asthma history, please describe (onset/treatment/duration): _____

_____

Are symptoms greater than twice a week or continuous? Circle: **YES** or **NO**

If yes, please describe frequency: _____

Circle Symptoms: coughing / chest tightness / wheezing / shortness of breath

If available, Peak Flow: _____AM/PM _____ AM/PM

Personal best PF: _____

Nighttime Symptoms? Circle: **Always** / **During Exacerbations Only** / **Never**
Exercise Symptoms? Circle: **Routine Activities** / **Vigorous Exercise** / **None**

ER visit or hospitalizations in the past 6 months? Please describe: _____

_____