AVANT ALLERGY & ASTHMA

Patient Name: ______________________________ DOB: ______________ Date: ________

Reason for today's visit: ____

Please check any of the following symptoms that apply to you:

_____ Nasal congestion _____Watery eyes _____Difficulty with exercise

_____Runny nose _____Cough _____Rash

_____Sneezing _____Wheezing _____Hives

_____Postnasal drip _____Shortness of breath _____Swelling

_____Itchy eyes _____Other: ____

Symptoms occur most often in the:

_____Spring _____Summer _____Fall _____Winter _____Year-Round

Please check if you have a history of any of the following conditions:

_____ Asthma _____Hives or swelling _____Reaction to insect sting

_____ Eczema _____Reaction to foods _____Reaction to medication

Drug allergies:

☐ No Known Drug Allergies

Name of drug	Reaction to drug
____________________	____
____________________	____

Current medications: List ALL medications you are taking (prescription, over-the-counter, supplements)

☐ No Current Medications

Name of medication	Dose	How often taken	For what condition
____________________	________	______________	____________________
____________________	________	______________	____________________
____________________	________	______________	____________________
____________________	________	______________	____________________
____________________	________	______________	____________________
____________________	________	______________	____________________

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Please check if anyone in your immediate family has a history of any of the following:

_____Asthma _____Environmental allergies _____Medication allergies

_____Eczema _____Food allergies _____Hives or Swelling

_____Other Family History: ____

Please list any prior surgeries:

Year	Type of surgery
____________________	____
____________________	____

Please list any prior hospitalizations:

Year	Reason for hospitalization
____________________	____
____________________	____

Environmental History:

Home: _____ Apartment _____House _____Other:________________________

Pets: _____Cat _______Dog _____Other:________________________

Carpet/area rugs: _____Bedrooms _____Living room _____Other:________________________

Curtains: _____Bedrooms _____Living room _____Other:________________________

Feathers: _____Pillows _____Comforter

Allergy covers : _____Mattress _____Pillow Air purifier: _____Yes _____No

Exposure to: Cockroaches: _____Yes _____No Mice: _____Yes _____No

Social history:

Occupation: ______________________________ Employer:________________________________

Smoking history: ☐ Current Smoker ☐ Former Smoker ☐ Never

____# of years ____# of packs/day ____Year Quit *(if applies)*

Exposed to second hand smoke? ____Yes _____No

Alcohol use: _____# of drinks per week _____# of drinks per year _____Never

Recreational drugs: ____Yes _____No _____Type:__________________

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Review of Systems:

Constitutional:
- ☐ Appetite change
- ☐ Unexpected_weight change
- ☐ Fever
- ☐ Chills
- ☐ Sweating profusely
- ☐ Fatigue

Eyes:
- ☐ Itching
- ☐ Redness
- ☐ Discharge
- ☐ Pain
- ☐ Light sensitivity
- ☐ Visual disturbance
- ☐ Eyelid swelling

Ears:
- ☐ Hearing loss
- ☐ Pain
- ☐ Redness
- ☐ Discharge

Nose:
- ☐ Runny nose
- ☐ Nasal congestion
- ☐ Sneezing
- ☐ Postnasal drip
- ☐ Itchy nose
- ☐ Sinus pressure
- ☐ History of nose bleeds
- ☐ History of sinus infection

Endocrine:
- ☐ Weight loss
- ☐ Weight gain
- ☐ Temperature intolerance
- ☐ Thyroid disease

Mouth & Throat:
- ☐ Dry mouth
- ☐ Itchy throat
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Trouble swallowing
- ☐ Snoring

Cardiovascular:
- ☐ Chest pain
- ☐ Irregular heartbeat or palpitations
- ☐ Heart Murmur
- ☐ Swelling of ankles/edema
- ☐ Syncope/blacking out

Respiratory:
- ☐ Cough
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Difficulty breathing

Gastrointestinal:
- ☐ Nausea
- ☐ Vomiting
- ☐ Abdominal pain
- ☐ Difficulty swallowing
- ☐ Constipation
- ☐ Diarrhea
- ☐ History of acid reflux
- ☐ History of food impaction

Musculoskeletal:
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint redness
- ☐ Limited movement
- ☐ Recent injury

Skin:
- ☐ Itchy skin
- ☐ Dry skin
- ☐ Rash
- ☐ Hives
- ☐ Swelling
- ☐ History of eczema

Neurological:
- ☐ Headache
- ☐ Dizziness
- ☐ Light headedness
- ☐ Numbness
- ☐ Weakness

Psychiatry:
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Mood changes
- ☐ Sleep disturbances

Patient Name: ______________________________ DOB: ________________

Responsible Party Signature: ______________________________ Date: ________________

Print Name *(if Responsible Party is other than self)*: ______________________________