HEALTHCARE CENTERS
of MORRIS HOSPITAL

ALLERGY HISTORY:

Reason for your visit today: _____

_____

Were you referred by a physician to see an allergist? If yes, please provide the Providers name, office phone and fax number:

_____

_____

PRIOR ALLERGY HISTORY:

Have you been evaluated by an allergist in the past? ☐ yes ☐ no

Have you ever been diagnosed with allergic rhinitis (environmental allergies)? ***If yes, please explain any important findings:***

_____

_____

_____

Have you had prior allergy skin testing performed? ***If yes, please explain any important findings*:**

_____

_____

_____

Have you received allergy injections in the past? ☐ yes ☐ no

If yes, when and how long were you treated with allergy injections:

_____

_____

_____

Have you been diagnosed with any food allergies? ☐ yes ☐ no

If yes, please list all foods and the reactions you have experienced?

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Food: _____ Reaction: _____

Do you avoid any foods? ☐ yes ☐ no *If yes, please list any foods you are avoiding*: _____

_____

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ENVIRONMENTAL HISTORY:

How long have you lived in your residence? ☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ > 10 years

Type of home? ☐ townhouse ☐ single family home ☐ apartment

Age of home, townhome or apartment unit? ☐ < 1 year ☐ 1-5 years ☐ 6-10 years ☐ 10-20 years ☐ > 20 years

Location of home? ☐ city ☐ rural area ☐ suburbs

Do you have a basement? ☐ yes (*check all that apply*) ☐ no

☐ crawl space ☐ finished ☐ unfinished ☐ seepage or leak ☐ wet or musty

Past flooding in the home? ☐ yes ☐ no

Type of heating in home? ☐ central forced air ☐ radiator (steam) ☐ solar ☐space/electric heater

Type of air-conditioning? ☐ none ☐ central A/C ☐ window unit

How often do you change air filters? ☐ every month ☐ every 3 months ☐ every 6 months ☐ once a year

Type of air filters? ☐ HEPA ☐ 3M ☐ 2M ☐ unknown

Do you keep your windows open in warmer months? ☐ yes ☐ no

Type of home ventilation? ☐ air purifier ☐ ceiling fans ☐ dehumidifier ☐ HEPA filters ☐ humidifier

☐ wood/coal stove or fire place

Do you have pets at home? *If yes, indicate number of each pet(s) you have:* ____ cats ____ dogs ____ birds

____ guinea pigs ____ hamsters ____ rabbits

Do pets sleep in your bedroom? ☐ yes ☐ no

Are there any tobacco smokers in the home? ☐ yes ☐ no

Do you use feather pillows or comforter? ☐ yes ☐ no

Do you have carpeting in the bedroom? ☐ yes ☐ no *If yes, how old in the carpet?* _____ years

PRIOR LAB WORK, TESTING OR CONSULTATIONS:

Have you had any prior autoimmune workup checking for rheumatologic conditions in the past? ☐ yes ☐ no

Have you had any prior testing/imaging: ☐ yes (*check all that apply*) ☐ no

☐ chest x-ray ☐ CT of chest ☐ CT of head ☐ CT of neck ☐ CT of sinuses ☐ GI endoscopy with biopsy

☐ MRI of the ear ☐ MRI of head ☐ MRI of sinuses ☐ prior sinus surgeries ☐ rhinoscope by ENT ☐ skin biopsy

Have you had any prior consultations: ☐ yes (*check all that apply*) ☐ no

☐ ENT ☐ dermatology ☐ gastroenterology ☐ pulmonary ☐ rheumatology

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Please describe all important lab, imaging and consultation findings from previous page: _____

_____

_____

NASAL OR SINUS CONCERNS *(if no concerns please **SKIP** to next section)*:

Do you have the following nasal or sinus symptoms consistently? ☐ yes (*check all that apply*) ☐ no

☐ burning in mouth ☐ clear, thin/think or white/yellow/green mucous ☐ congestion ☐ dark circles under eyes

☐ dry mouth ☐ dry gritty eyes ☐ ear pain ☐ ear plugging ☐ ear ringing ☐ hay fever ☐ headache

☐ hoarseness ☐itchy mouth or lips ☐ migraines ☐ nasal polyps ☐ nasal/sinus pressure ☐ pain in throat

☐ postnasal drip ☐ runny nose ☐ recurrent sinus infections ☐ red eyes ☐ scratchy throat ☐ sneezing

☐ sores in mouth ☐ watery eyes

How long have you been having symptoms? _____

What triggers your nasal symptoms? (please list any outdoor, indoor, irritant/chemical triggers)

_____

_____

Please list the name of all the prescription and over the counter and prescription allergy and sinus medications you have tried and if they worked:

_____

_____

_____

ASTHMA OR BREATHING CONCERNS *(if no concerns please **SKIP** to next section)*:

At what age were you first diagnosed with asthma? _____ ☐ never been diagnosed with asthma

How was the asthma diagnosed? _____

Do you have the following breathing issues or asthma like symptoms consistently? ☐ yes (*check all that apply*) ☐ no

☐ anxiety ☐ burning in chest ☐ chest pain with exhalation ☐ chest pain with inhalation ☐ chest tightness

☐ cold hands and feet ☐ y2ű ƎŜűűyƎ 2ÈèƎŜy ☐ dry cough ☐ productive cough ☐ fatigue from coughing

☐ hyperventilation ☐ mucous production ☐ nervousness ☐ pain in back

☐ rib pain ☐ pain in shoulder ☐ shortness of breath ☐ persistent wheezing

☐ any other symptoms _____

_____

Describe all that apply to the pattern and duration of your asthma or breathing problems:

☐ no pattern found ☐ rare and mild ☐ getting worse ☐ occurs at rest ☐ exercise/exertion ☐ morning

☐ afternoon ☐ evening ☐ throughout the day ☐ intermittent ☐ 1-2 times a week

☐ more than twice a week ☐ few times a month ☐ wakes me up at least once a week at night ☐ spring

☐ summer ☐ fall ☐ winter ☐ year round

List all the allergens, chemical, products or irritants that make your breathing worse?

_____

_____

_____

How many times a year do the following infections make your asthma or breathing worse?

☐ # of sinus bronchitis _____ ☐ # of pneumonias _____ ☐ # of recurrent URIs _____

☐ # of sinus infections _____

How many urgent care/ER visits have you had for asthma or breathing trouble in the past year? _____

How many oral or IV steroid courses for asthma in past year? _____

Were the symptoms alleviated with steroids? ☐ yes ☐ no

Number of days missed from work or school in past year due to breathing issues or asthma? _____

When was your last PFT or spirometry? _____

When was your last Chest X-ray or CT of chest? _____

How many time a week do you use your albuterol inhaler? _____

Please List name of ALL inhalers and dosage you have been prescribed in the past 2-3 years? _____

_____

_____

ALLERGIC REACTION, SWELLING, AND SKIN RASHES *(if no concerns please **SKIP** to next section)*:

Are you having any of the current skin problems or reactions? ☐ yes ☐ no

☐ anaphylactic/severe allergic reaction ☐ chronic itching ☐ eczema/atopic dermatitis ☐ hives ☐ rash

☐ swelling

Describe the characteristics of the current skin reaction(s) or rash: _____

_____

_____

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Where is the skin rash or allergic reaction occurring? (*check all that apply*)

☐ abdomen ☐ arms ☐ around eyes ☐ back ☐ chest ☐ eyebrow/eyelids ☐ face ☐ feet

☐ fingers ☐ groin ☐ hands/wrist ☐ legs ☐ lips ☐ neck ☐ thighs

Describe the pattern of the allergic reaction (*check all that apply*):

☐ no pattern found ☐ getting worse ☐ getting better ☐ intermittent ☐ lasts less than 12 hours

☐ lasts less than 24 hours ☐ lasts more than 24 hours ☐ occurring in evening or night ☐ occurring in the morning

☐ occurring once a day ☐ present all the time ☐ sporadic ☐ spreading everywhere

Does avoiding any foods alleviate skin condition? ☐ yes ☐ no *If yes, please list foods being avoided:*

_____

_____

Have you ever been stung by an insect? ☐ yes (*check all that apply*) ☐ no

☐ bee ☐ fire ant ☐ hornet ☐ mosquito ☐ spider ☐ wasp ☐ yellow jacket ☐ unknown

List any important details about the stinging insect reactions you have experienced: _____

_____

What triggers your skin condition (check only those that are effecting you skin)?

☐ acrylic nails ☐ adhesives ☐ alcohol based body/facial products ☐ anti-aging products ☐ bleach/chlorine

☐ body soap/wash ☐ cosmetics ☐ deodorants ☐ dishwashing soap ☐ dry ventilation ☐ dry-cleaned garments

☐ dust ☐ eye cream ☐ fabric softener/sheets ☐ fabric dye/new clothing ☐ feather pillows/bedding ☐ fertilizer

☐food dye/coloring ☐ fragrance ☐ hair dyes ☐ household cleaners ☐ insecticide ☐ jewelry ☐ latex

☐ laundry detergent ☐ leather belt ☐ lotions ☐ mold exposure ☐ mouthwash ☐ nail polish ☐ newspaper prints

☐ nickel ☐ nylon ☐ outdoor pollen (airborne) ☐ paint fumes ☐ paper boxes ☐ perfumes ☐ pets (cats/dog)

☐ polyester ☐ rubber ☐ sawdust ☐ spandex ☐ shampoo/conditioner ☐ stainless steel

☐ tight clothing/ elastic undergarment ☐ toothpaste ☐ wool

☐ List any other skin irritants: _____

Do any of the non-allergic triggers below effect your skin (check only those that effect your skin)?

☐ anger ☐ cold air ☐ cold object ☐ cold water ☐ cooking fumes/odors ☐ direct sun light

☐ dry air ☐ emotional stress ☐ exercise ☐ going from hot to cold temperature ☐ heat ☐ hot beverage/foods

☐ hot water/shower ☐ humidity ☐ prolonged pressure to skin ☐ rubbing or friction to skin

☐ submersion in water ☐ sleeping on back ☐ spicy foods ☐ sweating ☐ tobacco smoke ☐ vibration to skin

How many ER/urgent care visits have you had for skin rash or allergic reactions in the past 6 months? _____

Any new medications you have been started on within the past year of the skin condition starting? ☐ yes ☐ no

If yes, *please list name of medications and dosage taken:* _____

_____

_____

Do you think a particular medication(s) may be causing your symptoms? ☐ yes ☐ no

If yes, list medication(s): _____

_____

_____

Please list all medications that have been tried for your ongoing skin condition: _____

_____

Have you been prescribed an Epipen for any allergic reaction? *If yes, please describe for what reason you were prescribed this medication*:

_____

_____

_____

FOOD REACTION *(if no concerns please **SKIP** to next section)*:

List ALL confirmed food allergies OR list ANY foods you have experienced reactions to? *Please describe in detail.*

_____

_____

_____

Do you have the following symptoms from food ingestion consistently? ☐ yes (*check all that apply*) ☐ no

☐ abdominal pain ☐ anaphylaxis ☐ bloating ☐ blood in stool ☐ burning in mouth ☐ chest tightness

☐ constipation ☐ coughing ☐ diarrhea ☐ diffuse hives ☐ dizziness ☐ eczema/atopic dermatitis ☐ flushing

☐ gas ☐ headaches ☐ itchy mouth/lips ☐ itchy skin ☐ localized hives ☐ loose stools ☐ loss of consciousness

☐ migraines ☐ nausea ☐ numbness/tingling ☐ rashes ☐ runny nose ☐ shortness of breath ☐ sneezing

☐ sores in mouth ☐ swelling ☐ vomiting ☐ watery/itchy eyes ☐ wheezing

How often do these reactions occur? _____

_____

_____

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Did avoidance of certain foods above alleviate yours symptoms? ☐ yes ☐ no ☐ unsure

Have you been diagnosed with a food intolerance (such as lactose intolerance)? *If yes, list which foods and how were they diagnosed?*

_____

_____

Have you ever been prescribed an Epipen for a food reaction? *If yes, when was it last used?*

_____

_____

Are there any other important details that you think we should know about your concerns with foods?

_____

_____

_____

I have provided all accurate information regarding my current symptoms and medical health to the best of my ability for my visit to the Allergist.

Patient Signature: _____ **Date:** _____

MORRIS HOSPITAL
ALLERGY SPECIALISTS

Beta Blocker Screening Form

The medications listed below are "beta blockers", commonly used to treat high blood pressure, angina (chest pain), irregular heart rhythms, and migraine headaches.

Please place a check mark if you are currently taking any of the medications listed below:

Oral Medications

____ Betapace (Sotalol)
____ Blocadren (Timolol)
____ Bystolic (Nebivolol)
____ Cartrol (Carteolol)
____ Coreg (Carvedilol)
____ Corzide, Corgard (Nadolol)
____ Inderal, Innopran XL (Propranolol)
____ Inderide (Propranolol)
____ Kerlone (Betaxolol)
____ Levalol (Penbutolol)
____ Lopressor (Metoprolol)
____ Normodyne, Normozide (Labetalol)
____ Sectral (Acebutolol)
____ Tenoretic (Atenolol)
____ Tenormin (Atenolol)
____ Other: _____

____ Timolide (Timolol)
____ Toprol3XL, Toprol (Metoprolol)
____ Trandate (Labetalol)
____ Visken (Pindolol)
____ Zebeta (Bisoprolol)
____ Ziac (Bisoprolol)
____ Breviloc (Esmolol) – IV use

Eye Drop Section

____ Betopic (Betaxolol)
____ Betagan (Levobunolol)
____ Betimol (Timolol)
____ Corsopt (Timolol)
____ Istalol (Timolol)
____ Ocupress (Carteolol)
____ Optipranolol (Metipranolol)
____ Timoptic (Timolol)

If you should be started on any new medication(s) by your physician, please notify either our allergy nurse or physician in our office of any changes.

_____ I am currently on the medication(s) listed above

_____ I am currently NOT on any medication(s) list above

Patient Name: _____ **Date:** _____

Signature: _____