Valley Allergy Asthma and Eczema Care Inc
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Clovis, Ca 93611
Phone (559) 472-9716
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Patient Information

Name: _____

Date of Birth: ____ / ____ / _____ Age: _____ Sex: □ M □ F □ Other

Primary Care Provider: _____ Phone: _____

Referring Provider: _____ Phone: _____

Reason for Visit (check all that apply) □ Allergic Rhinitis (sneezing, runny nose, congestion) □ Asthma / Breathing problems □ Food Allergy or Food Reactions □ Eczema / Atopic Dermatitis □ Hives / Swelling □ Other:

_____

Main concern: _____

Allergic Rhinitis / Nasal & Eye Symptoms

□ Sneezing □ Runny nose □ Congestion □ Post-nasal drip □ Itchy/watery eyes Season: □ Spring □ Summer □ Fall □ Winter □ Year-round Triggers: □ Pollen □ Dust □ Animals □ Mold □ Weather □ Strong odors □ Other Prior treatments:

_____

Response: □ Yes □ No

Asthma / Breathing Symptoms

□ Cough □ Wheezing □ Chest tightness □ Shortness of breath Frequency: □ Daily □ Weekly □ Less often Nighttime symptoms: □ Never □ Sometimes □ Often ER/hospital visits past year: _____

Steroid use past year: _____

Current inhalers/medications: _____

Food Allergy

Foods causing reaction: _____

Reactions: □ Hives □ Swelling □ Cough/Wheezing □ Vomiting □ Diarrhea □ Anaphylaxis Time from eating to reaction: □ Minutes □ Hours □ Other

ER visits: □ No □ Yes (details: _____)

Carry Epinephrine: □ No □ Yes

Eczema / Atopic Dermatitis

□ Itchy rash □ Dry skin □ Thickened patches Age of onset: _____

Locations: □ Face □ Arms □ Legs □ Hands □ Other Triggers: □ Soaps □ Detergents □ Foods □ Weather □ Stress □ Other

Treatments: _____

Control: □ Good □ Fair □ Poor

Hives / Swelling (Urticaria / Angioedema)

□ Hives (itchy welts) □ Swelling of lips/eyes/hands/feet

Frequency: □ Daily □ Weekly □ Monthly □ Rare

Duration: □ <24 hrs □ >24 hrs

Triggers: □ Foods □ Medications □ Infections □ Pressure/Heat/Cold □ Unknown

Treatments tried: _____

Response: □ Yes □ No

Other Medical History

□ Asthma □ Allergic Rhinitis □ Eczema □ Food Allergy □ Hives/Swelling □ Sinus Infections □ Pneumonia □ Recurrent Infections □ Autoimmune Disease

□ Other: _____

Surgical History

□ Tonsillectomy □ Adenoidectomy □ Sinus Surgery □ Other: _____

Medications List all prescriptions, inhalers, sprays, OTC, supplements:

Medication Name	Dosage	Frequency

Medication & Other Allergies

□ No Known Allergies □ Yes → List:

_____

Family History Asthma:

□ Yes □ No (Who?)

_____

Allergic Rhinitis: □ Yes □ No (Who?)

_____

Eczema: □ Yes □ No (Who?)

_____

Food Allergy: □ Yes □ No (Who?)

_____

Hives/Swelling: □ Yes □ No (Who?)

_____

Autoimmune Disease: □ Yes □ No (Who?)

_____

Social & Environmental History Occupation:

Tobacco: □ Never □ Former □ Current

Pets: □ Cat □ Dog □ Bird □ Other-Specify:

_____

Home: □ House □ Apartment Place of living: □ City □ Suburb □ Country

Flooring- bedroom □ Carpet □ Hardwood □ Tile

Cooling: Central AC Room AC units

HEPA/air filters: □ Yes □ No

Mold/water damage: □ Yes □ No

Age of mattress: _____ Allergy protective covers on Mattress □ Yes □ No
Cockroach/Rodent exposure □ Yes □ No.

Consent & Acknowledgment

I consent to release of information for insurance and billing purposes. I acknowledge receipt of HIPAA privacy policies.

Patient/Guardian Signature: _____ Date: ____ / ____ / _____