

ADVANCED ALLERGY & ASTHMA, PLLC

Adult and Pediatric Allergy
Diplomate American Board of Allergy and Immunology

Ellen Epstein, M.D. FAAAAI, FAAAAI
165 North Village Avenue Suite 141
Rockville Centre New York 11570
Tel: (516) 678-0056

PATIENT INFORMATION

Last Name _____ First Name _____

Address _____

Zip Code _____ City _____ State _____

Phone: Home () _____ Work () _____

Cell () _____ Texting: Yes ___ No ___

E-Mail _____@_____.com

Marital Status: Single ___ Married ___ Divorced ___ Widowed ___

Date of Birth ___/___/___ SS# ___-___-___

Spouse's Name _____ Spouse's Phone Number () _____

Referred by _____

Address _____ Phone () _____

Ethnicity- ANSWER BOTH QUESTIONS Nos. 1 and 2:

1. Hispanic/Latino ___ Not Hispanic/Latino ___

2. American Indian/Alaska Native ___ Asian ___ White ___ Other ___

Black/African American ___ Native Hawaiian/Pacific Islander ___

If Child, Responsible Party: Name _____ D/O/B ___/___/___

Address _____

Zip Code _____ City _____ State _____

Phone: Home () _____ Work () _____

Cell () _____ SS# ___-___-___ D/O/B ___/___/___

Patient Employed by _____ Phone () _____

Address of Employer _____

Primary Care Physician _____ Phone () _____

Pharmacy Name _____ Pharmacy Phone () _____

Person to Contact in Emergency:

Name _____

Address _____ Relationship _____

Phone: Home () _____ Cell () _____

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PATIENT _____ **AGE** _____ **DATE** _____

COUNTRY OF BIRTH _____

RACE _____ **SEX** M F **MARTIAL STATUS** – Single Married Divorced Widow

REFERRED BY _____

HISTORY OF:	PERSONAL		PERSONAL (WHEN DID THIS OCCUR?)	FAMILY		FAMILY (SPECIFY MEMBER)
	YES	NO		YES	NO	
Allergies			REACTION:			
Atopic dermatitis/Eczema						
Hives						
Itchy water eyes						
Sinus Infection						
Headaches (Frequent or Severe)						
Asthma						
Nasal congestion						
Chest symptoms						
Heartburn/reflux						
Difficulty swallowing						
Drug Allergy (circle if allergic) Penicillin Aspirin Sulfa X-ray Dye Local anesthetic Non steroidal anti-inflammatory Other:						
Food Allergy , Mahi Mahi Trout/Tuna/Aged cheese			<u>List foods:</u>			
Sulfite/red wine Chianti						
Insect Allergy Ever stung?			<u>List insect:</u>			
Latex (rubber): Condom gloves balloons						
Abdominal Bleeding						
Anemia						
Anxiety						

HISTORY OF:	PERSONAL <u>(WHEN DID THIS OCCUR?)</u>		FAMILY <u>(SPECIFY MEMBER)</u>	
	YES	NO	YES	NO
Arthritis				
Back Disorders				
Backache				
Black Tarry Stools				
Bleeding Diseases				
Blood in Stool				
Cancer				
Cataracts				
Change in Bowel Habits				
Chest Pain				
Colitis				
Constipation (recent or persistent)				
Convulsion				
Cough (recent or persistent)				
Coughing Blood				
Depression				
Diabetes				
Diarrhea (recent or persistent)				
Difficulty Swallowing				
Dizziness				
Double Vision				
Enlarged Heart				
Emphysema				
Epilepsy				
Eye Problems				
Frequent Nighttime Urination				
Fainting Spells				
Gallstones				
Gall Bladder Disorder				
Glaucoma				
Heart Disease				
Heart Murmur				
Hepatitis				
High Blood Pressure				
Hoarseness of voice				
HIV or Exposure				
Treatment for HIV				

HISTORY OF:	PERSONAL <u>(WHEN DID THIS OCCUR?)</u>		FAMILY <u>(SPECIFY MEMBER)</u>	
	YES	NO	YES	NO
Indigestion				
Irregular Heartbeat				
Kidney Infection				
Kidney Stone				
Leg Pain				
Lung Disease				
Lyme Disease				
Nosebleeds				
Nervous Disorder				
Painful Urination				
Paralysis				
Phlebitis (blood clots)				
Pleurisy (lung problems)				
Pneumonia				
Pus in Urine				
Rash				
Rheumatic Fever				
Runny Nose				
Shortness of Breath				
Stroke				
Swelling of Feet				
Swollen/Painful Joints				
T.B.				
Thyroid Disease				
Ulcer				
Venereal Disease				

Personal and Social History	
Number of children	Healthy? Medical Problems:
Sexual Orientation	
Alcohol	How much: _____ times/day _____ social
Other Risk Factors	Occupational/Recreational
Recent Hospitalization	
Smoking	NEVER__ ACTIVE__ # PACKS PER DAY__ # of YEARS __ PRIOR __ WHEN STOPPED -----
Weekly Exercise	
Weight Variance This Year	

Vaccine Status	
Hepatitis B Vaccine	How many 1--- 2---- 3---
Chicken Pox (Varicella)	How many 1--- 2---- 3---
HIV Status	Date tested _____ Results _____

Occupation: Patient Spouse	Hobbies: Patient: Spouse:
Mammogram	Date of last: _____ Results: Normal ___ Abnormal ___
Pap Smear	Date of last _____ Results: Normal _____ Abnormal _____
Chest X-ray	Date of last _____ Results Normal _____ Abnormal _____
Last Menses	<u>Date:</u> _____ Normal _____ Abnormal _____
Pregnant	Due Date: _____
Immunizations:	Flu shot _____ Date _____ Pneumonia shot _____ Date _____
Recent Hospitalizations	
List all Present Medications including over the counter and vitamins	
ENVIRONMENTAL HISTORY	House _____ years old Apartment: _____ years old Length of occupancy _____ years Is it near factories___ barns___ bakeries___ swamp___ water___ Flooring: carpeting___ bedroom___ living area___ basement___ HEATING SYSTEM: Baseboard___ Forced Air___ Radiator___ A/C Room___ Central___ None___ Fans: ceiling___ window___ Humidifier: none___ room___ central___ Basement: dry___ damp___ musty___ Dehumidifier: none___ room___ central___ Smokers at home: yes___ no___ where do they smoke? _____ Feather pillow: yes___no___ Pets: cat dog bird rodent other

Completed by: _____ Date: _____
 First Name Last Name

Relationship to Patient: _____
 Self Other

Reviewed by: _____ Date: _____

Signature Ellen Epstein, M.D.