ADVANCED ALLERGY & ASTHMA, PLLC
Adult and Pediatric Allergy
Diplomate American Board of Allergy and Immunology

Ellen Epstein, M.D. FAAAAI, FACAAI
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 ( ) _____

Ellen Epstein, M.D. FAAAAI, FACAAI
Adult and Pediatric Allergy **165 North Village Avenue Suite 141**
Diplomate American Board of Allergy and Immunology **Rockville Centre New York 11570**
Tel: (516) 678-0056 Fax (516) 678-8395

PATIENT _____ **AGE** _____ **DATE** _____
COUNTRY OF BIRTH _____
RACE _____ **SEX M F** **MARTIAL STATUS – Single Married Divorced Widow**
REFERRED BY _____

HISTORY OF:	YES	NO	PERSONAL (WHEN DID THIS OCCUR?)	YES	NO	FAMILY (SPECIFY MEMBER)
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			**List foods:**			
Sulfite/red wine Chianti						
Insect Allergy Ever stung?			**List insect:**			
Latex (rubber): Condom gloves balloons						
Abdominal Bleeding						
Anemia						
Anxiety						

HISTORY OF:	YES	NO	PERSONAL (WHEN DID THIS OCCUR?)	YES	NO	FAMILY (SPECIFY MEMBER)
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:	YES	NO	PERSONAL (WHEN DID THIS OCCUR?)	YES	NO	FAMILY (SPECIFY MEMBER)
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	Date: _____ 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.