PATIENT NAME:

DATE OF BIRTH:

MEDICAL RECORD NUMBER:

ADDRESSOGRAPH STAMP OR LABEL

MENLO MEDICAL CLINIC
Affiliated with Stanford Hospital & Clinics

1300 Crane Street
Menlo Park, CA 94025
Appointment Line: (650) 498-6652

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Pediatric & Adult
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Patient's Name	Date of Birth
Date of Appointment	Referring Physician

1. INSTRUCTIONS: Please answer the questions as they relate to the person being evaluated. A complete, accurate record is important in learning about your allergy problem. Bring this completed form for your first appointment.

Briefly describe the reasons for your allergy visit and what you hope to accomplish:

2. PROBLEMS: Have you ever had the following conditions?

Y	N	(Check all items)	Age at Onset	Severity			Comments
				Mild	Mod.	Sev.	
		Asthma (Wheezing)					
		Any Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (Runny, stuffy, itchy nose, sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Frequent Infections					
		Food Reactions					
		Drug Reactions					
		Insect Reactions					

3. SYMPTOMS: Have you ever had any of the following? If not, leave blank

	How many days in the last month	Severity			Circle the Months Most Severe
		Mild	Mod.	Sev.	
Runny or stuffy nose					J F M A M J J A S O N D
Itchy nose					J F M A M J J A S O N D
Sneezing					J F M A M J J A S O N D
Itchy eyes					J F M A M J J A S O N D
Wheezing					J F M A M J J A S O N D
Coughing					J F M A M J J A S O N D
Wheezing or coughing with exercise					J F M A M J J A S O N D
Skin Problems					J F M A M J J A S O N D

4. FOOD REACTIONS: Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after the ingestion of any food or liquid? If yes, specify below.

Food	Approx. Date	Symptoms	Can food be eaten?		Date food last eaten
			Y	N	

5. Precipitating Factors/Triggers: For each item below, check the appropriate square to indicate whether your (or your child's) condition is affected by the following precipitants/triggers.

	Condition Made Worse	Condition Improved	No Change
Cutting or playing in grass, raking leaves			
High winds, riding in auto			
Other outdoor exposure			
Moldy/mildewed areas or items (basement, attic, etc.)			
Sweeping, dusting or vacuuming			
Smog, smoking or smoke exposure			
Air conditioning or heating			
Cleaning agents, detergents, ammonia, bleach, soap, conditioner, shaving cream, toothpaste, etc. Specify:			
Paint lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking odors, etc. Specify:			
Emotions (stress, anger, cry, laugh)			
Other strong odors. Specify:			
Medications: • Antihistamines or cold preparations • Asthma medications • Nose drops or spray. How often per day? • Aspirin • Other			
Exposure to animals. Specify:			
'Colds' or viruses			
Physical exertion or exercise			
Cold Weather			
Other factors:			

6. RESIDENCE: List your past residences with your most recent first. Only city and state required.

City & State	Effect on Symptoms (better, worse, no change
1	
2	
3	

7. PREVIOUS ALLERGY EVALUATION AND THERAPY

Have you ever had an allergy skin test(s)?
❒ Yes ❒ No If yes, date(s): _____Physician's Name:
Results of these tests (if possible, please provide us with a copy)

_____

_____

Have you ever received allergy injections? Were these of any benefit?
❒ Yes ❒ No If yes, date(s): _____ ❒ Yes ❒ No_____

Please list all medications that you are now taking Bring all these with you for your first appointment: **(Include Drug name, dose and times of day taken)**

_____
_____
_____
_____
_____

Please list all medications you have taken for allergies in the past:

_____
_____
_____

8. OTHER MEDICAL PROBLEMS: Have you ever had any of the following? Answer all items.

Check all items	Yes	No		Yes	No		Yes	No
Frequent Headaches	❒	❒	Pneumonia, number past			Kidney or Bladder		
Frequent Nosebleeds	❒	❒	Year _____	❒	❒	Trouble	❒	❒
Nasal Polyps	❒	❒	Coughed Up Blood	❒	❒	Liver Trouble		
Operation on Sinuses	❒	❒	Tuberculosis	❒	❒	(e.g. Hepatitis)	❒	❒
Sinus X-Rays	❒	❒	Chest X-ray	❒	❒	Frequent Diarrhea	❒	❒
Ear infections			Heart Trouble	❒	❒	Bedwetting	❒	❒
No. past year _____	❒	❒	High Blood Pressure	❒	❒	Poison Ivy or		
Hearing Problems	❒	❒	Colic or Spitting Up as			Poison Oak	❒	❒
Glaucoma	❒	❒	an infant	❒	❒	Other _____	❒	❒
Tonsils/Adenoids	❒	❒	Frequent Heartburn	❒	❒			
Removed (date) _____			Diabetes	❒	❒			
What is your weight now?_____			Weight 1 year ago? _____			Maximum Weight:_____ When? _____		

9. HOSPITALIZATIONS/SURGERY

List most recent first	Reason	Date
1.		
2.		
3.		
4.		

10. FAMILY HISTORY

Do any members of your family have a history of allergy?

	Yes	No	If yes, list all relations (e.g. parents, brothers, sisters, children, aunts, uncles, grandparents, etc.)
Asthma			
Hay Fever			
Eczema			
Hives			
Swelling			
Frequent Pneumonia			
Headaches			
Other Allergies			
Food Reactions			
Drug Reactions			
Insect Reactions			

Is there a family history of any other illnesses?			
	Yes	**No**	**If yes, list all relatives**
Emphysema or Other Lung Disease			
Cystic Fibrosis			
Tuberculosis			
Thyroid Disease			
Glaucoma			
Diabetes			
Other			

11. ENVIRONMENTAL SURVEY	
Where do you live: (city or rural)	Number of indoor plants:
Age of House: Years	House construction (brick, wood, etc.):
Are any rooms damp or musty?	Do you have: (a) an air cleaner? (b) an air dehumidifier?
Type of heating (forced air, steam, space heater, baseboard, electric, etc.)	Type of air conditioning (central, window, etc.)
Type of Carpet (wool, synthetic, jute) : Bedrooms:_____ Living Room:_____ Den_____ Dining Room_____ **Pad** under carpet (rubber, ozite, hair) : Bedrooms:_____ Living Room:_____ Den_____ Dining Room_____	
How old is your: Pillow? Mattress?	Do you have any: Stuffed furniture? Feather comforters?
Is your pillow: ❒ feather ❒ foam rubber ❒ dacron ❒ other _____ ❒ encased in plastic	Is your mattress: ❒ foam rubber ❒ cotton ❒ innerspring & cotton ❒ waterbed ❒ encased in plastic ❒ other _____
What kinds of grasses, shrubs, and trees are in the immediate vicinity of your house?	
Do you have pets? List number and kind (dog, cat, birds, horses, etc.)	Do your pets spend time indoors? ❒ Yes ❒ No
What type of work do you do?	
Are you exposed to anything at work that might aggravate your conditions? Which things?	
Have you missed any time from work or school because of your allergies? How much time?	
Do you have any other exposures from hobbies, recreational activities, etc.?	

12. EDUCATION	**13. MARITAL STATUS**
Grade School (Highest grade) _____ High School (1 2 3 4) College (1 2 3 4) Other _____	❒ Married ❒ Single ❒ Divorced ❒ Widowed ❒ Separated Number of Children: _____

14. SMOKING
Have you ever smoked? ❒Yes ❒ No If yes, how many years? _____Do you presently smoke? ❒ Yes ❒ No When did you stop? _____ Average cigarettes per day at highest point? _____ If you still smoke, do you think you could stop? ❒ Yes ❒ No Which other family members now smoke?_____