ALLERGYSA.COM
Allergy, Asthma & Immunology
ASSOCIATES OF SOUTH TEXAS

# Patient Screening Form

**Date:** _____ **Patient's Name:** _____ **Age:** _____

**Patient's Primary MD:** _____ **Practice Type:** GP FP Internist Peds
**Other:** _____

**Who referred you to this clinic?** Self-referred Primary MD **Other:** _____

**Patient's symptoms: (check all that applies):**

- ☐ Eye symptoms *Age when started* _____
- ☐ Nose symptoms *Age when started* _____
- ☐ Snoring *Age when started* _____
- ☐ Sinus symptoms *Age when started* _____
- ☐ Cough *Age when started* _____
- ☐ Acid Reflux *Age when started* _____
- ☐ Difficulty breathing *Age when started* _____
- ☐ Recurring infections *Age when started* _____
- ☐ Other problems: _____

- ☐ Asthma/Wheezing *Age when started* _____
- ☐ Hives or Swelling of skin *Age when started* _____
- ☐ Persistent Rash or Eczema *Age when started* _____
- ☐ Food Reactions *Age when started* _____
- ☐ Drug Allergy *Age when started* _____
- ☐ Insect Sting Allergy *Age when started* _____

**Environmental triggers:**

- ☐ Trees
- ☐ Grasses
- ☐ Weeds
- ☐ Molds
- ☐ Dogs
- ☐ Cats
- ☐ Dust

- ☐ Being Indoors
- ☐ Being Outdoors
- ☐ School
- ☐ Workplace
- ☐ Strong Odors
- ☐ Weather Changes
- ☐ Strong Emotions

**When are symptoms the most severe?**

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter
- ☐ All Year

- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Night
- ☐ All Day

**Previous Allergy History**

Has the patient ever been tested for allergies in the past? **Yes** **No** If "Yes" when? _____

**Main Office:**
Medical Center
2414 Babcock Rd. Ste 109
San Antonio, TX 78229

**Southside:**
SW Medical Bldg.
7500 Barlite Blvd. Ste 106
San Antonio, TX 78224

**Stone Oak:**
Physician Plaza 1
19016 Stone Oak Pkwy. Ste 250
San Antonio, TX 78258

**T:** 210-616-0882
**F:** 210-692-7833
**allergysa.com**
revised 03/24/2015

Has the patient ever been on allergy shots in the past? **Yes** **No** If "Yes" when? _____

**Asthma History**

Have you ever been intubated, placed in intensive care, or on a respirator for asthma? _____
Number of hospitalizations for asthma: _____
Number of emergency room visits for asthma in the last year: _____

## Medications:

Current medications: _____

**Please List Others:**

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____

**Antibiotics in the past 6 months**: _____

**Steroids (injection or oral) in the past 6 months**: _____

**Medication Allergies**: _____

**Please list any ENT surgeries the patient has had and indicate their age at the time:**

_____

_____

**Please list any significant injuries the patient has had to their head or chest (eg., broken nose, etc):**

_____

_____

**Family History**

Does anyone in **the patient's** immediate family have any of the following problems?

| | Nasal allergies | Sinus problems | Asthma | Food allergies | Skin allergies |
|---|---|---|---|---|---|
| **Patient's Mother** | | ☐ | ☐ | ☐ | ☐ |
| **Patient's Father** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Brothers/sisters** | ☐ | ☐ | ☐ | ☐ | ☐ |
| **Patient's Children** | ☐ | ☐ | ☐ | ☐ | ☐ |

**Social History**

If the patient is a minor, who has custody? _____

Who does the patient live with? _____

Do you smoke tobacco products?

☐ Current Smoker - Everyday, Packs per day _____, Number of Years _____

☐ Former Smoker, Quit in year _____, Packs per day _____, Number of Years _____

☐ Never Smoked

Are there smokers in the home? ☐ Yes ☐ No Who? _____

Alcohol use: Yes _____ No _____ Socially _____ Never _____

Do you live in a ☐ house or ☐ apartment?

How old is the home? _____ How long have you lived in the home? _____

Does the home have mold or has had mold problems? _____

Is there carpet in the house? ☐ Yes ☐ No How old is the carpet in the home? _____

Indoor pets? ☐ Yes ☐ No

Who lives in the home with the patient? _____

Any family members attend day care? _____

What is your occupation? _____

Is the patient exposed to any of the following?

Fireplace Wood-burning stove Strong fumes/chemicals Pollution

**Dietary History**:

Are there any foods that cause you an allergic reaction?

| *Food* | *Reaction* |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

All 3 pages reviewed by provider: _____ Date: _____