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ALLERGY AND ASTHMA CARE  
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TELEPHONE: (845) 362-3222  
FAX: (845) 362-2508

**PLEASE COMPLETE PRIOR TO VISIT**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_

GIVE A HISTORY OF YOUR SYMPTOMS:

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SYMPTOMS OCCUR:  ALL YEAR  SPRING  SUMMER  AUTUMN  WINTER  
 OTHER \_\_\_\_\_

WHAT MAKES YOUR SYMPTOMS WORSE? \_\_\_\_\_

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WHAT MAKES YOUR SYMPTOMS BETTER? \_\_\_\_\_

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WHAT MEDICATIONS HAVE YOU TRIED FOR THESE SYMPTOMS? DO THEY HELP?

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HAVE YOU SEEN AN ALLERGIST BEFORE? WHEN?

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PLEASE LIST THE MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING NON-PRESCRIPTION MEDICATIONS AND VITAMIN SUPPLEMENTS. \_\_\_\_\_

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NAME AND ADDRESS OF YOUR PRIMARY CARE PHYSICIAN: \_\_\_\_\_

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ARE YOU ALLERGIC TO ANY MEDICATIONS? \_\_\_\_\_ IF YES, PLEASE LIST: \_\_\_\_\_

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**PLEASE CHECK IF APPLICABLE**

DOES ANYONE IN YOUR HOUSEHOLD SMOKE?  YES  NO

HAVE YOU EVER SMOKED?  YES  NO

IF YES, AT WHAT AGE DID YOU START? \_\_\_\_\_

HOW MANY PACKS PER DAY? \_\_\_\_\_

AT WHAT AGE DID YOU QUIT, IF APPLICABLE? \_\_\_\_\_

ALCOHOL USE: \_\_\_\_\_ NOT APPLICABLE \_\_\_\_\_ SOCIAL \_\_\_\_\_ DRINKS/WEEK

HEATING SYSTEM:  FORCED HOT WATER  FORCED HOT AIR  ELECTRIC BASEBOARD

AIR CONDITIONING:  YES  NO  CENTRAL OR  WINDOW UNIT

HUMIDIFIER:  YES  NO  CENTRAL OR  ROOM UNIT

ANIMAL EXPOSURE:  CAT  DOG  BIRD  COCKROACH  OTHER \_\_\_\_\_

CARPETS IN BEDROOM:  YES  NO WALL-TO-WALL?  YES  NO

CARPETS IN LIVING AREAS:  YES  NO ALL-TO-WALL?  YES  NO

UPHOLSTERED FURNITURE:  BEDROOM  LIVING AREAS

TYPE OF MATTRESS:  REGULAR  WATER AGE OF MATTRESS: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY:**

THYROID DISEASE  DIABETES  HIGH BLOOD PRESSURE

KIDNEY DISEASE  GLAUCOMA  HEART DISEASE

DEPRESSION  LIVER DISEASE  OTHER: \_\_\_\_\_

HAVE YOU HAD A CHEST X-RAY DONE:  YES  NO  IF YES, APPROX. YEAR \_\_\_\_\_

**FAMILY ALLERGY HISTORY:**

MOTHER:  ASTHMA  HAYFEVER  ECZEMA  HIVES  FOOD  MEDICATION ALLERGY  BEESTING ALLERGY

FATHER:  ASTHMA  HAYFEVER  ECZEMA  HIVES  FOOD  MEDICATION ALLERGY  BEESTING ALLERGY

BROTHER/SISTER: (CIRCLE ONE)  ASTHMA  HAYFEVER  ECZEMA  HIVES  FOOD  MEDICATION ALLERGY  
 BEESTING ALLERGY

CHILDREN: SON OR DAUGHTER  ASTHMA  HAYFEVER  ECZEMA  HIVES  FOOD  MEDICATION ALLERGY  
(CIRCLE ONE)  BEESTING ALLERGY

GRANDPARENT: MATERNAL PATERNAL  ASTHMA  HAYFEVER  ECZEMA  HIVES  FOOD  MEDICATION ALLERGY  
(CIRCLE ONE)  BEESTING ALLERGY

UNCLES/AUNTS: (CIRCLE ONE)  ASTHMA  HAYFEVER  ECZEMA  HIVES  FOOD  MEDICATION ALLERGY  
 BEESTING ALLERGY

