STEVEN M. SOCKIN, M.D., F.A.C.A.A.I., F.A.A.A.I.

ALLERGY AND ASTHMA CARE 500C NEW HEMPSTEAD ROAD NEW CITY, NY 10956

DIPLOMATE AMERICAN BOARD OF ALLERGY & IMMUNOLOGY FELLOW, AMERICAN COLLEGE OF ALLERGY & IMMUNOLOGY FELLOW, AMERICAN ACADEMY OF ALLERGY & IMMUNOLOGY

TELEPHONE: (845) 362-3222 FAX: (845) 362-2508

PLEASE COMPLETE PRIOR TO VISIT

NAME:	AGE:				
GIVE A HISTORY OF YOUR SYMPTOMS:					
SYMPTOMS OCCUR:	□ ALL YEAR □ SPRING □ SUMMER □ AUTUMN □ WINTER □ OTHER				
WHAT MAKES YOUR	SYMPTOMS WORSE?				
WHAT MAKES YOUR	SYMPTOMS BETTER?				
WHAT MEDICATIONS	HAVE YOU TRIED FOR THESE SYMPTOMS? DO THEY HELP?				
HAVE YOU SEEN AN A	ALLERGIST BEFORE? WHEN?				
	DICATIONS YOU ARE CURRENTLY TAKING, INCLUDING NON-PRESCRIPTION MEDICATIONS AND ITS.				
NAME AND ADDRESS	OF YOUR PRIMARY CARE PHYSICIAN:				
ARE YOU ALLERGIC 1	O ANY MEDICATIONS? IF YES, PLEASE LIST:				

REV. 12/2016

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PLEASE CHECK IF APPLICABLE

DOES ANYONE IN YOUR HOUSEHOLD SMOKE? \square YES \square NO	
HAVE YOU EVER SMOKED? \square YES \square 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: \square YES \square NO \square CENTRAL OR \square WINDOW UNIT	
HUMIDIFIER: □YES □ NO □CENTRAL OR □ ROOM UNIT	
ANIMAL EXPOSURE: CAT COCKROACH OTHER OTHER	
CARPETS IN BEDROOM: \square YES \square NO WALL-TO-WALL? \square YES \square NO	
CARPETS IN LIVING AREAS: \square YES \square NO ALL-TO-WALL? \square YES \square 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:	
\square HAVE YOU HAD A CHEST X-RAY DONE: \square YES \square NO \square 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)	
CHILDREN: SON OR DAUGHTER ASTHMA HAYFEVER ECZEMA HIVES FOOD MEDICATION ALLERGY	
(CIRCLE ONE)	
GRANDPARENT: MATERNAL PATERNAL □ASTHMA □ HAYFEVER □ECZEMA □HIVES □FOOD □MEDICATION ALLERO	Y
(CIRCLE ONE)	
UNCLES/AUNTS: (CIRCLE ONE) ASTHMA HAYFEVER ECZEMA HIVES FOOD MEDICATION ALLERGY DEFESTING ALLERGY	
☐BEESTING ALLERGY	

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Do you take any antibiotics before	re ge	tting dental tr	reatments? Y N	
Hematologic/Lymphatic			Integumentary	
Bleeding problem	Y	N	Skin Rash	Y
Blood clotting problem	Y	N	Boils	Y
Swollen Glands Other	Y 	N	Persistent Itch Other	Y
Eyes			Musculoskeletal	
Blurred Vision	Y	N	Joint pain/Swelling	Y
Double Vision	Y	N	Neck Pain	Y
Pain	Y	N	Back Pain	Y
Glaucoma		N	Artificial Joints	Y
Other	******		Other	www.
Neurological			Endocrine	
Tremors	Y	N	Excessive Thirst	Y
Dizzy Spells		N	Too Hot/Cold	Y
Numbness/Tingling	Y	N	Tired/Sluggish	Y
Other			Other	
Cardiovascular			Genitourinary	
Chest Pain	Y	N	Blood in Urine	Y
Varicose Vein		N	Urine Retention	Y
High Blood Pressure		N	Urinary Frequency	Y
Heart Murmur/Valve		N	Other	
Calf pain when walking Other	Y	N		
Gastrointestinal			Constitutional Symptoms	
Abdominal Pain	Y	N	Fever	Y
Nausea/Vomiting	Y	N	Chills	Y
Indigestion/heartburn	Y	N	Frequent Cough	Y
Change in Bowel movement	Y	N	Shortness of Breath	Y
Blood in Bowel movement		N	Other	-
Jaundice	Y	N		
Other				