

Name _____ Age _____ Today's Date _____

In a few words, the reason for my visit to Dr. Wein is _____

My primary doctor is (if any): _____ I was referred by (if any): _____

Were you ever allergy tested? Yes No Did you receive allergy injections? Yes No Where /When?

Now or in the past I have had:

- | | | | | |
|---------------------------------------|---|---|---|--|
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Sinus Problem | <input type="checkbox"/> Nasal Polyp | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> _____ |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema/Rash | <input type="checkbox"/> Thyroid | <input type="checkbox"/> Immune Problems | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Food Allergy | <input type="checkbox"/> Contact Lenses | <input type="checkbox"/> Alcohol Treatment | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Cataracts | <input type="checkbox"/> Insect Allergy | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Pneumonia Vaccine | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Latex Allergy | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Frequent Headaches | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Chest X-ray | <input type="checkbox"/> Hiatal Hernia | <input type="checkbox"/> Nosebleeds | <input type="checkbox"/> Tonsil Surgery | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Heartburn | <input type="checkbox"/> Ear infection | <input type="checkbox"/> Hearing problem | <input type="checkbox"/> Liver Disease |

My other medical conditions are _____

I have had surgery for _____

Current Medications: _____

Medications I avoid because of allergy or intolerance: _____

Family History : Asthma Eczema Hayfever Cancer Sinus Heart disease Other:

Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Brother or Sister	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____

I've lived in Florida _____ years. I also lived in _____ . Marital Status _____ Children _____

Other people living at home: _____

Hobbies/School: _____ Foreign countries visited? _____

What type of work do you do? _____ Previous occupation: _____

What aggravates your condition? _____

What makes it better? _____

What else have you tried? _____

Tell us about other exposures or anything else important... _____

_____ Smoking (age started and stopped) _____

Any symptoms (rash, hay fever, asthma, stomachache, loose bowels, nausea) after food :

- MILK FISH ALCOHOL EGGS SHELLFISH COFFEE FRUITS WHEAT PEANUTS
 VEGETABLES CHEESES MELON TOMATOES CELERY OTHER NUTS OTHER _____

I have recently had: _____

- | | | | |
|------------|--|--------|---|
| General | <input type="checkbox"/> fatigue <input type="checkbox"/> chills <input type="checkbox"/> weight change | Heart | <input type="checkbox"/> chest tightness <input type="checkbox"/> palpitations |
| Ear/Throat | <input type="checkbox"/> snoring <input type="checkbox"/> hearing loss <input type="checkbox"/> hoarse voice | Joints | <input type="checkbox"/> joint pain <input type="checkbox"/> joint swelling |
| Stomach | <input type="checkbox"/> diarrhea <input type="checkbox"/> nausea, <input type="checkbox"/> heartburn | Urine | <input type="checkbox"/> bloody <input type="checkbox"/> urine, <input type="checkbox"/> weak stream |
| Lungs | <input type="checkbox"/> wheeze <input type="checkbox"/> cough <input type="checkbox"/> short of breath | Skin | <input type="checkbox"/> dryness <input type="checkbox"/> itching <input type="checkbox"/> rash, <input type="checkbox"/> hives |
| Nerves | <input type="checkbox"/> dizziness <input type="checkbox"/> fainting <input type="checkbox"/> tremors | Other, | for example do you smoke? Yes No |

Other concerns I have are...

Thank you for allowing us to help you. Please tell us anything else which might help us to help you.
