



**Allergy & Asthma  
Associates  
of Southern California**

Leading-edge, personalized care you can trust

27800 Medical Center Road, Suite 244 • Mission Viejo, CA 92691  
15785 Laguna Canyon Road, Suite 100 • Irvine, CA 92618  
Tel: (949) 364-2900 • Fax: (949) 365-0117  
www.SoCalAllergy.com

**William E. Berger, M.D. Warner W. Carr, M.D. Mark S. Sugar, M.D.**  
Diplomates of the American Board of Allergy and Immunology

**PATIENT NAME:** \_\_\_\_\_ **TODAY'S DATE:** \_\_\_\_\_  
**DATE OF BIRTH:** \_\_\_\_\_ **SEX:** M F **AGE:** \_\_\_\_\_  
**EMAIL ADDRESS:** \_\_\_\_\_ **PHONE:** \_\_\_\_\_  
**REFERRED BY:** \_\_\_\_\_ **PCP:** \_\_\_\_\_

**INSTRUCTIONS FOR COMPLETING HEALTH QUESTIONNAIRE:** If you are unable to complete this form online or prefer to fill out a hard copy, please print and complete this document, bringing it with you when you arrive for your first appointment. This form is designed to help find the cause of your problem and is an essential part of your evaluation, aiding in the proper selection of tests and treatments, and allowing us to spend more time focusing on your important problems. When possible, please provide a start and stop date for all medical conditions as well as provide a check box in the Med Taken box if you are currently taking medication for that condition. If you have a condition that is not listed please add it in the OTHER section.  
**\*\*PLEASE NOTE: No antihistamines, such as Claritin, Allegra, Zyrtec, or Benadryl for at least 72 hours before your appointment, as they interfere with allergy testing. Asthma medications are allowed if needed for wheezing and coughing. If you are unsure of any medication you are presently taking, please call our office for instructions. \*\***

**CHIEF COMPLAINT:** (The main reason you are here)

---

---

**HISTORY OF PRESENT ILLNESS** (Please provide a brief description of your current condition)

---

---

---

---

---

---

Please List All Current Medications	Dosages

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

Please indicate if you have **EVER** been diagnosed with any of the medical conditions listed below

<p><b>Allergies</b></p> <p><input type="checkbox"/> Hayfever or Allergic Rhinitis (Stuffy, Runny, Itchy Nose, Sneezing) Symptoms Worse: <input type="checkbox"/> Indoors <input type="checkbox"/> Outdoors <input type="checkbox"/> Both</p> <p><input type="checkbox"/> Allergic Conjunctivitis (Red, Itchy Eyes)</p> <p><input type="checkbox"/> Food Allergy List Each Food and Reaction: _____ _____</p> <p><input type="checkbox"/> Stinging Insect Allergy (Bee, Wasp, Hornet, Etc.)? _____</p> <p><input type="checkbox"/> Drug Allergies List Each Drug and Reaction: _____ _____</p> <p><b>Eyes, Ears, Nose &amp; Throat</b></p> <p><input type="checkbox"/> Sinus Infections <span style="margin-left: 150px;"><input type="checkbox"/> Ear Infections</span></p> <p><input type="checkbox"/> Nasal Polyps <span style="margin-left: 150px;"><input type="checkbox"/> Hearing Loss</span></p> <p><input type="checkbox"/> Bloody Nose <span style="margin-left: 150px;"><input type="checkbox"/> Cataracts</span></p> <p><input type="checkbox"/> Tubes in Ears <span style="margin-left: 150px;"><input type="checkbox"/> Glaucoma</span></p> <p><b>Lungs/Pulmonary</b></p> <p><input type="checkbox"/> Asthma If yes: <input type="checkbox"/> Have you ever used oral steroids for Asthma/COPD? Date: _____</p> <p><input type="checkbox"/> Have you ever been hospitalized Asthma/COPD? Date: _____</p> <p><input type="checkbox"/> # of ER visits in the past year for Asthma/COPD # _____</p> <p><input type="checkbox"/> How many times per week do you use your rescue medication? #: _____</p> <p><input type="checkbox"/> Pneumonia Date: _____ <input type="checkbox"/> Pulmonary Embolism Date: _____</p> <p><input type="checkbox"/> Smoking Packs/Day _____ Yrs of Smoking: _____ Date Quit: _____</p> <p><b>Skin/Dermatologic</b></p> <p><input type="checkbox"/> Eczema <input type="checkbox"/> Hives Other Rash: _____</p> <p><b>Endocrine</b></p> <p><input type="checkbox"/> Diabetes <input type="checkbox"/> Thyroid Disease</p> <p><input type="checkbox"/> Other Endocrine Problems: _____</p>	<p><b>Heart/Cardiovascular</b></p> <p><input type="checkbox"/> High Blood Pressure <span style="margin-left: 150px;"><input type="checkbox"/> High Cholesterol</span></p> <p><input type="checkbox"/> Heart Attack <span style="margin-left: 150px;"><input type="checkbox"/> Heart Murmur</span></p> <p><input type="checkbox"/> Angina or Chest Pain <span style="margin-left: 150px;"><input type="checkbox"/> Arrhythmias</span></p> <p><b>Digestive/Gastrointestinal</b></p> <p><input type="checkbox"/> Ulcer <span style="margin-left: 150px;"><input type="checkbox"/> Irritable Bowel</span></p> <p><input type="checkbox"/> Acid Reflux or Heartburn <span style="margin-left: 150px;"><input type="checkbox"/> Diarrhea</span></p> <p><input type="checkbox"/> Nausea or Vomitting <span style="margin-left: 150px;"><input type="checkbox"/> Hepatitis</span></p> <p><b>Genitourinary/Gynecological</b></p> <p><input type="checkbox"/> Urinary Tract Infections <span style="margin-left: 150px;"><input type="checkbox"/> Genital Herpes</span></p> <p><input type="checkbox"/> Enlarged Prostate <span style="margin-left: 150px;"><input type="checkbox"/> Hysterectomy</span></p> <p><input type="checkbox"/> Menopause</p> <p><b>Rheumatologic</b></p> <p><input type="checkbox"/> Osteoarthritis <span style="margin-left: 150px;"><input type="checkbox"/> Rheumatoid Arthritis</span></p> <p><input type="checkbox"/> Osteoporosis <span style="margin-left: 150px;"><input type="checkbox"/> Other: _____</span></p> <p><b>Neurologic</b></p> <p><input type="checkbox"/> Migraine Headaches <span style="margin-left: 150px;"><input type="checkbox"/> Sinus Headaches</span></p> <p><input type="checkbox"/> Stroke <span style="margin-left: 150px;"><input type="checkbox"/> Seizures</span></p> <p><input type="checkbox"/> Other Neurologic Disorder: _____</p> <p><b>Psychiatric</b></p> <p><input type="checkbox"/> Depression <span style="margin-left: 150px;"><input type="checkbox"/> Anxiety</span></p> <p><input type="checkbox"/> Bipolar Disorder <span style="margin-left: 150px;"><input type="checkbox"/> ADD/ADHD</span></p> <p><input type="checkbox"/> Other Psychiatric Disorder: _____</p> <p><b>Other Chronic Medical Conditions:</b></p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
--	--

PATIENT NAME: \_\_\_\_\_

DOB: \_\_\_\_\_

<b>Cancer</b> (Please specify type): 	<b>Environmental</b> <input type="checkbox"/> Carpet <input type="checkbox"/> Smokers in the home <input type="checkbox"/> Pets (If yes, select type) <input type="checkbox"/> Cat <input type="checkbox"/> Dog <input type="checkbox"/> Other: _____
<b>Surgical Procedures</b> (List any previous surgeries and dates) 	<b>Review of Systems</b> Please indicate any <b>Current</b> problems in the following areas:
	<b>General</b> <input type="checkbox"/> Chills <input type="checkbox"/> Fever <input type="checkbox"/> Weightloss <input type="checkbox"/> Fatigue
<b>Previous Evaluation</b> <input type="checkbox"/> Allergy Tested Before? Date: _____	<b>Eyes</b> <input type="checkbox"/> Change in vision <input type="checkbox"/> Itchy <input type="checkbox"/> Red <input type="checkbox"/> Watery
<input type="checkbox"/> Received Allergy Injections? Date: _____	
<input type="checkbox"/> Pulmonary Function Testing? Date: _____	
Medications that made your symptoms better: _____	<b>Ears</b> <input type="checkbox"/> Ear Infection <input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Ear Popping
Medications tried but did not help: _____	<b>Nose</b> <input type="checkbox"/> Congestion <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sneezing <input type="checkbox"/> Itchy Nose <input type="checkbox"/> Sinus Infection <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Seasonal Allergies
<b>Family History</b> (Check all that apply & the relationship)	<b>Throat</b> <input type="checkbox"/> Sore Throat <input type="checkbox"/> Change In Voice
<input type="checkbox"/> Hayfever? Relationship: _____	
<input type="checkbox"/> Asthma? Relationship: _____	
<input type="checkbox"/> Sinus Problems? Relationship: _____	
<input type="checkbox"/> Eczema? Relationship: _____	<b>Respiratory</b> <input type="checkbox"/> Shortness of Breath <input type="checkbox"/> Cough <input type="checkbox"/> Pain With Breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Problems with exercise
<input type="checkbox"/> Bronchitis? Relationship: _____	
<input type="checkbox"/> Emphysema? Relationship: _____	
<input type="checkbox"/> Cystic Fibrosis? Relationship: _____	
<input type="checkbox"/> Diabetes? Relationship: _____	<b>Cardiovascular</b> <input type="checkbox"/> Chest Pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Arrythmias <input type="checkbox"/> Leg Swelling
<input type="checkbox"/> Heart Disease? Relationship: _____	
<b>Social History</b> School: _____ Grade: _____	<b>Gastrointestinal</b> <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> GERD or Acid Reflux <input type="checkbox"/> Diarrhea <input type="checkbox"/> Food Allergy
Occupation: _____	
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit Packs Per Day? _____ How many years? _____	<b>Reproductive</b> <input type="checkbox"/> Penile Discharge <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Breast Pain <input type="checkbox"/> Breast Lump <input type="checkbox"/> Sexual Dysfunction
Exposed to second hand smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit How many drinks per week? _____	
Do you drink caffeine (Coffee/Tea/Caffeinated Soda)? <input type="checkbox"/> Yes <input type="checkbox"/> No Type: _____ Cups/Day: _____	<b>Skin</b> <input type="checkbox"/> Hives <input type="checkbox"/> Red Rash <input type="checkbox"/> Itchy Rash <input type="checkbox"/> Contact Allergy
Do you use any illicit drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Quit Type: _____	

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

**Review of Systems (continued)**

<b>Neurologic</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Headache <input type="checkbox"/> Numbness <input type="checkbox"/> Vertigo/Room Spinning	<b>Psychiatric</b> <input type="checkbox"/> Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Increased Stress
<b>Musculoskeletal</b> <input type="checkbox"/> Back Pain <input type="checkbox"/> Joint Pain <input type="checkbox"/> Muscle Aches	<b>Other (Please Describe):</b> _____ _____

PLEASE NOTE: ALL INFORMATION SUBMITTED ON THIS FORM IS CONSIDERED SECURE HEALTHCARE INFORMATION AND IS HELD IN THE STRICTEST CONFIDENCE, PROTECTING YOUR RIGHTS TO PRIVACY.

**QUESTIONNAIRE COMPLETED BY:** \_\_\_\_\_

**RELATIONSHIP TO PATIENT:** \_\_\_\_\_

**DATE COMPLETED:** \_\_\_\_\_

<b>FOR OFFICE USE ONLY</b> This history form has been reviewed and discussed in detail with the patient.	
_____ Physician Signature	_____ Date