

Allergy and Asthma Center
Anita N. Wasan, MD, FAAP, FACAAI
6824 Elm Street, Suite 120
McLean, VA 22101 (703) 992-7065

TODAY'S DATE: _____

PATIENT NAME: _____

IF SKIN TESTING, HAVE YOU HAD AN ANTIHISTIMINE WITHIN THE PAST 5 DAYS?

YES: _____ NO: _____

VITALS (For office use only):

BP: _____ HR: _____ TEMP: _____ HEIGHT: _____ ft. _____ in.

WEIGHT: _____ lbs.

PATIENT INFORMATION:

PATIENT DOB: _____

PRIMARY CARE PHYSICIAN:

REASON FOR VISIT:

PLEASE LIST YOUR OCCUPATION:

ARE YOU ALLERGIC TO ANY MEDICATIONS/LATEX? (Please list):

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | |
| 3) _____ | |

LIST ANY MEDICATIONS TAKING TO INCLUDE "OVER-THE-COUNTER" MEDICATIONS (To include dosage/frequency):

- | | |
|----------|----------|
| 1) _____ | 3) _____ |
| 2) _____ | 4) _____ |

DO YOU HAVE ANY MEDICAL CONDITIONS (Please list):

HAVE YOU EVER BEEN HOSPITALIZED/HAD ER VISITS/ANY SURGERIES? (Please list):

DO YOU HAVE ASTHMA/BEEEN HOSPITALIZED/HAD ER VISITS FOR ASTHMA? IF YES, PLEASE LIST WHEN YOUR LAST SYMPTOMS WERE AND DATES OF HOSPITALIZATION:

DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

- Eczema: _____
- Ear Infections (How many):

- Bronchitis (Average number/Year or total): _____
- Sinus Infections (Average number/Year or total):

- Strep Throat or Pharyngitis (Average number/Year or total): _____

HOW OLD IS YOUR HOME: _____ HOW OLD IS YOUR CARPET: _____

DO YOU LIVE WITH ANY PETS? (If yes, please list how many and what type):

HAVE YOU EVER AND/OR USED TOBACCO PRODUCTS? YES _____ NO _____

(IF YES) WHEN? :

IS THERE ANY TOBACCO EXPOSURE IN YOUR HOME AND/OR WORK?

YES _____ NO _____

DO YOU DRINK ALCOHOL? NO _____ YES _____ (If yes how often) _____

LIST ALL MEDICAL CONDITIONS THAT EXIST IN YOUR FAMILY INCLUDING WHO HAS THEM:

Pharmacy Name: _____

City/State: _____

Pharmacy Number: _____

ARE YOUR IMMUNIZATIONS UP TO DATE? YES: _____ NO: _____

SYSTEM REVIEW: (Please circle any of the following symptoms/condition that you have):

- Blurry Vision/Visual Problems
- Heartburn
- Abdominal Pain
- Thyroid Problems
- Gas/Bloating/Flatulence
- Cold/Heat Intolerance
-
- Diarrhea/Constipation
- Sneezing/Nasal Congestion/ Runny Nose
- Wheezing
- Itchy Eyes
- Cough
- Musculoskeletal Pain
- Pain/Swelling of Joints
- Rash/Skin Problems
- Hair Loss
- Numbness of Extremities
- Difficulty in Urination
- Back Pain