Thomas Chacko, M.D

Adult and Pediatric Allergy/Immunology

Name: _____ Date of Birth:_____ Today's Date:_____

Primary Care Physician:_____ Height: _____ Weight:_____

Pharmacy Name:_____ Pharmacy Phone Number:+_____

Have you had any tests/surgeries for this problem? _____

Who referred you to us? _____

Please list reasons for visit: **1:**_____

2:_____

Please circle if having any of the following symptoms or complaints:

1.Hay Fever/Allergies **2.**Reaction to Insect Stings **3.**Reaction to Medication **4.**Nasal Problems
5.Frequent Infections **6.**Rash or Itchy Skin **7.**Asthma or Difficulty Breathing **8.**Sinus Infections **9.**Swelling
10. Food Allergy **11.**Other_____

If Hay Fever symptoms, when are symptoms worse? (Spring, Summer, Fall, or Winter?)

_____

Any other triggers (such as dogs, cats, foods or anything else)?

_____

What allergy medications have you tried? Which (if any) have helped improve the way you feel?

_____

_____

If asthma, have you ever been to the E.R., hospitalized, and/intubated for asthma?_____

Current Medications:

Name Strength # of times per day taken

1.
2.
3.
4.
5.
Can add other medication on back of sheet

Any other current medical problems:_____

Please circle any personal history:

1.Eczema 2.Food Allergy 3.Insect Allergy 4.Hives or Swelling

Pets in home?_____ **If so, what kind?**_____

Past Surgical History:	Surgery Date of Surgery
1.	
2.	
3.	
4.	

Social History:

Alcohol: never occasional regular (amount/day_____)

Tobacco: never former (year stopped:_____) current (____packs/day for_____years)

Smokers at home: yes or no

Drugs of abuse: never former (year stopped:_____) current

Employment: _____ Years in Atlanta?_____

Married/single/other: _____Do you have any children and if so, how many?_____

Allergic History:

Previously been seen by an allergist? Yes or No

If yes: Name of physician/year/location_____

Have you ever been on Allergy injections? If so when?_____

Carpeting in the house? Yes or No Location:_____

What kind of dwelling place do you live in? (House,Apartment,etc.)_____

Approximately when was your dwelling place constructed?_____

Allergies to Medications: please indicate the type of reaction that occurred:

_____

History of	Yes	No	History of	Yes	No
Weight changes			Snoring		
Fever/chills			Sleepiness during the day		
Heartburn			Abdominal pain		
Fatigue			Nausea/vomiting		
Cough			Sinus pain/Pressure		
Congestion			Constipation		
Decreased sense of smell			Diarrhea		
Hearing loss			Recurrent infections		
Hoarseness			Chest Pain		
Nose bleeds			Wheeze		
Post nasal drip			Shortness of breath w/exercise		
Recurrent Infections			Wheeze		