Neha Madhok Bhambri, MD

Name: _____ D.O.B: _____

The reason for your visit and history of your symptoms: □Allergy □Immunology

_____

_____

_____

Symptoms occur: □all year □spring □summer □fall □winter

What medications have you tried for these symptoms? Do they help?

_____

_____

Have you ever seen an allergist before? □yes □no Were you ever on allergy shots? □yes □no
Have you ever seen an Ear, Nose, Throat (ENT) doctor before? □yes □no Have
you ever seen a dermatologist before? □yes □no

What other medical problems do you have? _____

_____

What surgeries have you had and what year did you have them in? _____

_____

Please list all medications that you are currently taking, including vitamins and herbal supplements including doses:

Date started	Medication	Dose

Are you allergic to any medications? □ yes □ no
If yes, list medication and the reaction: _____

Are you allergic to any foods? □ yes □ no
If yes, please list: _____

Environmental/Social History:

Have you ever smoked? □ yes □no Does anyone in your household smoke? □ yes □no
If yes, what age did you start? _____ How many packs per day? ____ What age did you quit? _____

Do you live in a: □house □condo □apartment □condo How many years have you lived there? _____

Animal exposure: □dog □cat □bird □cockroach □mouse □other _____

Bedroom: □carpets □heavy drapes □stuffed animals □upholstered furniture Living areas: □carpets □heavy drapes □upholstered furniture

Heating system: □hot water □forced hot air □baseboard □radiator □gas Air conditioning: □central □window units

Do you use feather/down pillows or comforters? □yes □no

Are you currently employed? □yes □no If yes, what do you do for a living? _____

Family History:

Mother: Age____	□asthma □hayfever □eczema □hives □sinus
Father: Age____	□asthma □hayfever □eczema □hives □sinus
Siblings: __Brother(s) __Sister(s)	□asthma □hayfever □eczema □hives □sinus
Children: __Son(s) __Daughter(s)	□asthma □hayfever □eczema □hives □sinus

Are there any other medical problems that run in your family? _____

Please remember to bring this questionnaire with you on the day of your appointment.

Patient Signature: _____ Date: _____

Reviewed by: _____ Date: _____