HIGHLAND CLINIC

FAX FORM TO 4451

DATE:___________

ALLERGY/IMMUNOLOGY
PATIENT HISTORY FORM

PCP / REFERRING MD
____

Name:____DOB:_________________________Age:______________

Reason for Visit: ____

____

____

Allergies to Medications and Type of Reaction: ____

____

Past Medical History: *Do you have?*

- ☐ None ☐ Heart Disease ☐ Lung Disease ☐ Diabetes ☐ Thyroid Disease
- ☐ Cancer ☐ Liver Disease ☐ GERD/Reflux ☐ Asthma ☐ High Blood Pressure
- ☐ HIV ☐ Kidney Disease ☐ Hepatitis

Immunizations: *Are your immunizations up to date?* ☐ yes ☐ no

Pneumonia Shot __________year Seasonal Flu Shot __________year

H1N1 Flu Shot __________year Measles/Mumps/Rubella __________year

Prevanar __________year COVID __________year COVID Booster? ☐yes ☐ no

Social History:

Smokes ☐ yes ☐ no former Type:____________________# per day_________________Years smoked________

Alcohol Consumption ☐ yes ☐ no Second Hand Smoke ☐ yes ☐no

Family History:

☐ None ☐ High Blood Pressure ☐ Heart Disease ☐ Depression ☐ Rheumatology Disease

☐ Hayfever ☐ Asthma ☐ Food Allergy ☐ Eczema

Current Medications: *Drug Name Dose/Strength How you take it (for example, 1 a day, 2 a day, etc).*

____ ____

____ ____

____ ____

____ ____

____ ____

____ ____

Tell me about your home

☐Foundation ☐Pier Beam ☐Foundation and Pier Beam `

☐Apartment ☐Mobile home ☐Townhome ☐Brick ☐Wood ☐Brick & Wood

Age of Home________________ Smoker in Home: ☐yes ☐no

Has there been any water damage? ☐yes ☐ no

Carpet: ☐yes ☐no Age of carpet______ Which rooms have carpet? _________________________

Heating/AC: ☐Gas Heat/Electric Air ☐Central heating & Air ☐Windows Unit

Bedroom Layout

How old is the mattress? ______________ Ceiling Fan: ☐yes ☐no

Pillow: ☐Feather ☐Foam Blinds on Windows: ☐yes ☐no

Pets: ☐yes ☐no Do any pets sleep in the bedroom? ☐yes ☐no Where? ☐bed ☐floor ☐cage

Hobbies: ____