Allergy & Asthma Centers Of RI
Dr. Russell Settipane
Dr. Robert Settipane
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All Board Certified Allergists
Telephone (401)331-8426

Initial Allergy History

Date: _____
Name: _____
Age: _____
Were you referred by another Doctor , NP, or PA? ☐ **Yes** ☐ **No**
Referred By: _____

ALL PATIENTS PLEASE FILL OUT SECTION A, PAGES 1-3, THEN FILL OUT SECTION B OR C IF APPLICABLE.

A. General – check all that apply

☐ Stuffy or runny nose, sneezing, post-nasal drip, sinus or eye problems (Please also fill out section B)

☐ Asthma, wheezing, shortness of breath, cough, chest congestion (Please also fill out section C)

☐ Reaction to insect stings

☐ Eczema/dermatitis/skin rashes

☐ Hives, angioedema, swelling, urticaria

☐ Possible allergies to drugs/medications/shots

☐ Possible allergies to foods (Please inform our staff if you are requesting food allergy testing)

☐ Other (specify)_____

Please state why you are here and what it is that you desire to result from today's visit:

_____

_____

_____

Please List Current Medicines- include all prescription and over-the-counter drugs you take, including eye drops, nose sprays, vitamins, birth control pills, etc.

Name of Medicine	Amount (mg., puffs, etc.)	Times/Day	Check one	
			Every Day	As Needed

Past Medical History:

Other Chronic Conditions — Age or Year

_____ since _____
_____ since _____
_____ since _____

Hospitalizations:

Approx Year

_____ for _____
_____ for _____
_____ for _____

Emergency Visits:

How many times in the past year _____

How many times in the past 5 years _____

Drug/ medication allergies: Symptom When reaction happened

1._____ caused _____ _____ years ago

2._____ caused _____ _____ years ago

3._____ caused _____ _____ years ago

Are you allergic to Aspirin or non-steroidal anti-inflammatory meds? ☐Yes ☐No

If yes, please describe reaction:_____

Previous allergy testing:

Tested by _____ Date: _____

Testing positive for _____

Received shots: ☐ No ☐Yes From Year_____ to Year_____

If yes, then the shots helped: ☐ a lot ☐ somewhat ☐ a little ☐ not at all

If yes, did you have any bad reactions to the shots? ☐ no ☐ yes (Describe) _____

_____

_____

_____

Review of systems:

Yes No

☐ ☐ Fever, weight loss, fatigue_____

☐ ☐ Problems, with eyes _____

☐ ☐ Problems with ears, nose, mouth, throat _____

☐ ☐ Heart problems or high blood pressure _____

☐ ☐ Lung problems (other than asthma)_____

☐ ☐ Stomach upset/ reflux/ bowel problems_____

☐ ☐ Bladder, urinary, or kidney problems _____

☐ ☐ Joint swelling or pain _____

☐ ☐ Skin problems / rashes _____

☐ ☐ Depression or other pyschiatric problems _____

☐ ☐ Migraines or neurological problems _____

☐ ☐ Problems with thyroid, diabetes, other endocrine_____

☐ ☐ Problems with blood counts, anemia, cancer _____

Immunizations you have received: Year

Influenza vaccine (most recent) _____

Pneumococcal vaccine _____

Tuberculosis test _____

Family History

Which of your blood relatives have (or have had) the following problems:

Asthma _____ Migraines_____

Hay fever / sinus problems _____ Tuberculosis_____

Eczema_____ Other_____

Hives / swelling _____

Social History

What type of work / school do you currently do? _____
What fumes / chemicals / etc. are you exposed to? _____
Are symptoms worse at work? _____

Are you a smoker? ☐ No ☐ Yes ____ PPD for ____ years

☐ Quit ____years ago after smoking ___ ppd for ___years

Environmental Hx:

Bedroom:

☐ feathers/down pillow or comforter Age of pillows:_____ Age of mattress:_____

☐ air conditioner ☐ air cleaner ☐ humidifier ☐ dehumidifier ☐ rugs ☐ wall to wall carpeting

House:

☐ cats for ___ years ☐ dogs for ___ years ☐ other (_____) for ___ years

☐ smokers in house ☐ wood stove used ☐ problems with mold/mildew

How old is house? _____ How many years in this house? _____

What type of heat? __ hot air/vents __ hot water/baseboard __ steam radiators
__ electric heat __ space heaters

B: Nose/Sinus/Eye problems (if applicable)

Check all that apply:

☐ stuffy nose ☐ post- nasal drip ☐ sneezing ☐ itchy eyes ☐ itchy nose, ears, palate

☐ sinus pressure/pain ☐ headaches ☐ runny nose ☐ watery eyes

Symptoms have been present for _____ years/months

Symptoms occur: ___year round
___year round, but worse in: ☐ spring ☐ summer ☐ fall ☐ winter
___only in ☐ spring ☐ summer ☐ fall ☐ winter

Symptoms are worse: ☐ at home ☐ at work ☐ indoors ☐ outdoors ☐ in morning ☐ at night

Symptoms worse near: ☐ animals (_____) ☐ dust ☐ fresh cut grass
☐ damp weather ☐ cold ☐ warm dry air
☐ smoke ☐ perfumes ☐ detergents
☐ food (_____) ☐ anxiety ☐ other _____

Medicines that have helped: _____

Medicines you have tried that have **not** helped _____

Any history of: ☐ broken nose ☐ deviated septum ☐ nasal polyps ☐ sinus surgery?

C: ASTHMA/BREATHING PROBLEMS (if applicable)

When did you start having this type of problem?_____

How often do you now have symptoms of cough, wheeze, or shortness of breath?

☐2 days/week or less ☐3-6 days/week ☐nearly every day

How often do you have problems sleeping or wake during the night because of asthma?

☐ 2 nights/month or less ☐3-4 nights/month ☐more than once/week

How much work/school have you missed due to asthma in the last 6 months? _____

What triggers your asthma?

☐ catching a cold	☐ strenuous exercise	☐ mild exercise
☐ cold weather	☐ damp weather	☐ air conditioning
☐ smoke	☐ fumes	☐ stress/anxiety
☐ dust	☐ pollen	☐ animals (_____)
☐ aspirin	☐ other medicines (_____)	☐ beer/wine
☐ other foods (_____)	☐ other (_____)	

What medicines for asthma do you take every day? _____

What medicines for asthma do you take only as needed? _____
How often do you need this? _____Times per: (Circle One) Day Week Month

Do you have a spacer for your inhalers? _____

Do you have a peak flow meter at home? ☐ yes ☐ no

If yes, what is your personal best peak flow? _____ What have recent peak flows been? _____