Chicago Family Asthma & Allergy, S.C.
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Thank you for coming to visit us! Here are some details about your first visit at CFAA…

The visit for patient ____ is on the date of _______________ at time ______________.

- Our banner is located above our building entrance on Clark St. **There are two entrances marked "2551" at the street level; take the north (left) doorway to access our office.**
- Valet parking is available for $8 Monday-Thursday 9-5 and Friday 9-12.
- Street parking on Clark is $1 per hour. For the adventurous spirit, side streets may have free spots. Plan to park for up to 2 hours for new patient visits. Arrive 15 minutes prior to your appointment time to check-in.
- Bring your insurance card and a form of ID. Parents, your driver's license will do for a child patient's ID.
- If your insurance requires a co-pay for your visit, be prepared to pay this at each visit.
- If your insurance requires a referral for specialist visits (ex. HMO, some POS), please have your doctor fax it to us prior to the visit or bring it with you. *Without the referral, you will be responsible for payment of the visit.*
- If you may have allergy skin testing at your visit, **you must be off antihistamines for 5 days**. It is best to check with us or your doctor before discontinuing any medications that are important to maintain your health. Examples of common antihistamines include:

Acrivistine	Alavert	Allegra	Astelin	Astepro	Atarax
Benadryl	Brompheniramine	Carbinoxamine	Cetirizine	Chlorpheniramine	Clarinex
Claritin	Clemastine	Cyproheptadine	Desloratadine	Dexchlorpheniramine	Diphenhydramine
Doxylamine	Fexofenadine	Hydroxyzine	Levocetirizine	Levocabastine	Loratadine
Meclizine	Olopatadine	Patanase	Periactin	Pheniramine	Promethazine
Pyrilamine	Tripelennamine	Tripolidine	Xyzal	Zyrtec	

- **Complete the following patient history and bring it to the appointment to expedite your visit time.**

1. Summary of reason for visit:

____
____
____
____

2. Symptom triggers (circle or complete):

Dust
Insect sting
Cat
Dog
Other animal: __________________________
Medicine: ______________________________

Perfumes
Fumes
Odors
Humidity
Air cleaners
Weather changes

Stress/Anxiety
Fresh-cut grass
Seasons: ________________________________
Year-round
Food: __________________________________
Other: __________________________________

3. Medications (include doses or strengths and frequency taken)

Current: ____
Medications that helped allergies: ____
Medications that did not help: ____
Any side effects: ____

4. Ever had allergy tests in the past? (circle) No Yes: Skin or Blood or Other
   If yes, list results and bring copy to appointment: ___________________________

5. Ever had "allergy shots"? Y or N If so, to what and how long? ___________________________

6. Ever had oral corticosteroids (steroid liquid or pills)? Yes or No
   If so, how many times and when? ___________________________

7. Family history:

	Asthma	nasal allergies	hay fever	eczema	food allergy	drug allergy	cystic fibrosis	immune deficiency
Mom	☐	☐	☐	☐	☐	☐	☐	☐
Dad	☐	☐	☐	☐	☐	☐	☐	☐
Sister	☐	☐	☐	☐	☐	☐	☐	☐
Brother	☐	☐	☐	☐	☐	☐	☐	☐
Aunt/Uncle	☐	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐	☐

List any other history of significant medical illness in family: ___________________________
____

8. Social history (please circle):
   Home: House Condo Apt New If old, age of home: __________ Recent remodeling: Yes or No
   Heating: forced air radiator baseboard space heater fireplace (wood or gas)
   Air conditioning: central window none Air filters: central room freestanding HEPA filter
   Humidifier: No Yes: central freestanding in bedroom
   Carpet: No Yes: in bedroom not in bedroom Rugs: No Yes: in bedroom not in bedroom
   Dust control: dust mite coverings: No Yes: pillow mattress Pillow: synthetic feather
   Comforter: synthetic feather Stuffed animals: No Yes: in bed bedroom not in bedroom
   Basement: No Yes: damp or dry History of water or flood damage No Yes: fixed not fixed
   Animals in home: No Yes: cat dog other:_______________ allowed in bedroom not in bedroom
   Smokers at home: No Yes: patient other outdoors indoors
   Occupation, or list education level if student: ___________________________
   If patient is child, do they attend preschool or day care? No Yes: days per week: ___________________________
   Recent travel outside the United States: No Yes: when and where: ___________________________

9. Past medical history (include pertinent dates and reasons):
   Hospitalizations: ___________________________
   Surgeries: ___________________________
   Seen by other specialists: ___________________________

10. Review of systems (circle "No" or explain if "Yes"):
   General: any recent fever, weight loss or gain, other: No Yes: ___________________________
   Eyes: contacts, glaucoma, cataracts, other: No Yes: ___________________________
   Ears, nose, throat: recurrent ear infections, nasal polyps, enlarged adenoids or tonsils, other: No Yes: __________________
   ____
   Neurologic: headache, migraines, other: No Yes: ___________________________
   Chest/respiratory: lung disease, other: No Yes: ___________________________
   Cardiovascular: heart disease, chest pain, other: No Yes: ___________________________
   Gastrointestinal: reflux, diarrhea, constipation, other: No Yes: ___________________________
   Genitourinary: bladder or kidney problems, pregnancy, other: No Yes: ___________________________
   Endocrine: thyroid disease, diabetes, other hormone disorders: No Yes: ___________________________
   Immune: recurrent infections, sinusitis, pneumonia, ear infections: No Yes: ___________________________
   ____
   Skin: eczema, hives, rashes, other: No Yes: ___________________________
   Psych: anxiety, depression, stress, other: No Yes: ___________________________
   Hematology/oncology: cancer, bleeding disorder, other: No Yes: ___________________________