



Chicago Family Asthma & Allergy, S.C.
 2551 N Clark St, Suite 100, Chicago, IL 60614
 773-388-2322, fax 773-388-2333
chicagofamilyasthma.com

Thank you for visiting us! Please review and complete both pages. You may email the form to us at cfaa@chicagofamilyasthma.com (email not used for questions or clinical purposes) or bring it to your appointment.

Patient name: _____ Date of Birth: _____ Date of first office visit: _____

- See the “Find Us” tab on our website for location and parking details (parking can be a challenge).
- Plan to be in the office for **two (2) hours** for new patient visits. It usually does not take that long, but it is better to be prepared and to park accordingly.
- **Bring your current insurance card and a form of identification.** Your driver license will do for a child patient 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 the primary care provider send 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 the provider recommends skin testing, the patient should not take antihistamines for at least five (5) days prior to the visit.** Do not stop daily medications without the guidance of a medical practitioner or if you feel it is unsafe. Call us for advice if you are not sure if the medicine you are using should be stopped before the visit. Skin tests are not mandatory, and sometimes blood tests may be done without stopping any medicine.
- **Antihistamines to avoid for five (5) days before skin testing include:**
 - **Common oral liquids or tablets (including chewable/dissolvable):** cetirizine (Zyrtec), cyproheptadine (Periactin), desloratadine (Clarinex, Aeries), diphenhydramine (Benadryl), fexofenadine (Allegra), hydroxyzine (Atarax), levocetirizine (Xyzal), loratadine (Claritin, Alavert), and many over-the-counter cold medicines that may include antihistamines.
 - **Some gastroesophageal reflux (GERD) or heartburn medicines:** cimetidine (Tagamet), famotidine (Pepcid), nizatidine (Axid), and ranitidine (Zantac).
 - **Antihistamine nasal sprays:** azelastine (Astelin, Astepro), Dymista, and olopatadine (Patanase).
 - **Antihistamine eye drops:** ketotifen (Zaditor, Alaway, others), olopatadine (Pazeo, Pataday, Patanol), azelastine (Optivar), epinastine, bepotastine (Bepreve), alcaftadine (Lastacaft), and a few other over-the-counter antihistamine preparations.

1. Summary of reason for visit:

2. Check or list suspected or known **symptom triggers or patterns:**

- | | | | | |
|---|--|---|-------------------------------------|-------------------------------|
| <input type="checkbox"/> Pollens | <input type="checkbox"/> Spring season | <input type="checkbox"/> Late summer/fall season | <input type="checkbox"/> Year-round | <input type="checkbox"/> Dust |
| <input type="checkbox"/> Cat | <input type="checkbox"/> Dog | <input type="checkbox"/> Other animal (list): _____ | | |
| <input type="checkbox"/> Perfumes/Fumes | <input type="checkbox"/> Odors | <input type="checkbox"/> Moldy environments | <input type="checkbox"/> Smoke | |
| <input type="checkbox"/> Weather or temperature changes | <input type="checkbox"/> Humidity | <input type="checkbox"/> Stress or anxiety | | |
| <input type="checkbox"/> Other (describe): _____ | | | | |

3. **Medications** (include doses or strengths and frequency taken, or bring with you to the visit)

Current Medications: _____

Medication allergies or side effects: Check here if none known. Otherwise list names, symptoms, and year they occurred:

4. If you ever had **allergy tests** or **allergy shots** in the past, please bring a copy of results and past medical records to your appointment, or have your past medical provider fax these records to us at 773-388-2333.

5. Family history (check any that apply):

	Asthma	Nasal allergies	Eczema	Food Allergy	Cystic fibrosis	Immune Deficiency
Mom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dad	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sibling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Aunt or uncle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Grandparent	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Other significant medical illness in family: _____

6. Social history:

Animals in home: No Yes: cat(s) dog(s) other: _____ allowed in bedroom not in bedroom

Smokers at home: No Yes: patient other person outdoors indoors

If the patient is a child, do they attend preschool or day care? No Yes

Carpet in home: No Yes: in bedroom not in bedroom Dust control: dust mite bedding covers: No Yes

Stuffed animals: in bed not in bed Down/feather comforters or pillows: No Yes

History of water or flood damage in home or known mold problems: No Yes: fixed not fixed

7. Past medical history (include pertinent dates and reasons):

Hospitalizations or Surgeries: _____

List any chronic medical illness or disorder and if seen by other specialists: _____

8. Review of systems: Please check Yes (Y) or No (N)

System	Yes/No	System	Yes/No	System	Yes/No
General:		Gastrointestinal:		Genitourinary:	
Recent fever	<input type="checkbox"/> Y <input type="checkbox"/> N	Reflux	<input type="checkbox"/> Y <input type="checkbox"/> N	Bladder problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N	Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N	Kidney problems	<input type="checkbox"/> Y <input type="checkbox"/> N
Lethargy	<input type="checkbox"/> Y <input type="checkbox"/> N	Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N	Currently pregnant	<input type="checkbox"/> Y <input type="checkbox"/> N
Immune:		Chest:		Neurologic:	
Frequent antibiotics	<input type="checkbox"/> Y <input type="checkbox"/> N	Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N	Headache	<input type="checkbox"/> Y <input type="checkbox"/> N
Recurrent sinusitis	<input type="checkbox"/> Y <input type="checkbox"/> N	Coughing	<input type="checkbox"/> Y <input type="checkbox"/> N	Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N
Pneumonia	<input type="checkbox"/> Y <input type="checkbox"/> N	Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N	Other	<input type="checkbox"/> Y <input type="checkbox"/> N
Immune deficiency	<input type="checkbox"/> Y <input type="checkbox"/> N	Lung disease	<input type="checkbox"/> Y <input type="checkbox"/> N		
Skin:		Cardiovascular:		Psychologic:	
Eczema	<input type="checkbox"/> Y <input type="checkbox"/> N	Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N	Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N	Depression	<input type="checkbox"/> Y <input type="checkbox"/> N
Swelling	<input type="checkbox"/> Y <input type="checkbox"/> N	Passing out	<input type="checkbox"/> Y <input type="checkbox"/> N	Other	<input type="checkbox"/> Y <input type="checkbox"/> N
Hives	<input type="checkbox"/> Y <input type="checkbox"/> N				
Eyes:		Ear, Nose, Throat:		Please explain Yes responses, if needed:	
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N	Nasal congestion	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	
Redness	<input type="checkbox"/> Y <input type="checkbox"/> N	Nasal drainage	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	
Swelling	<input type="checkbox"/> Y <input type="checkbox"/> N	Discolored nasal discharge	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	
Contacts or glasses	<input type="checkbox"/> Y <input type="checkbox"/> N	Nasal polyps	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	
Cataracts or glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N	Enlarged adenoids, tonsils	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	
Endocrine/hormone:		Hematology:		_____	
Thyroid disease	<input type="checkbox"/> Y <input type="checkbox"/> N	Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N	Blood disorder	<input type="checkbox"/> Y <input type="checkbox"/> N	_____	

Patient name: _____ DOB: _____