AHN PEDIATRICS
Pediatric Alliance

For office use only:
Height: _____ Inches
Weight: _____ lbs
Blood pressure: _____

Adult and Pediatric Allergy, Asthma & Immunology

Patient Name_____ DOB: _____Date:_____

Reason for Visit ___Check-up ___Sick visit ___New problem

Which of the following are you being seen for:
___ Nasal and/or eye allergies
___ Asthma
___ Food allergies and if so, which foods_____
___ Drug allergies and if so, which drugs_____
___ Bee sting allergy
___ Hives
___ Eczema
___ Recurrent infections and if so, what types of infections: ___ear ___sinus ___pneumonia
___ Other_____

Do you currently receive any of the following injections for asthma or allergies?
___Allergy shots ___Fasenra ___Xolair ___ Dupixent ___Nucala
If yes, what was date started _____
If yes, are you due for an injection at today's visit? _____

Any new medical problems since last visit? **___Yes___ No**
Any changes to pets since last visit? **___Yes___ No**
Any new medical problems in family history since last visit? **___Yes___ No**

If yes to any of the above, please detail the change below.
_____

_____

List ALL medications you are currently taking including prescription and over the counter medications
Name **Dose** **How often**
_____

_____

_____

_____

If your pharmacy has changed, please list name and phone number
_____

Signature of person completing this form_____