ALLERGY CONSULTANTS Review of Medical History

Patient Name: _____ Date of Birth: _____
Date of Service: _____

Problem Review: please check yes or no if the patient has the problems listed:

Problem	Y	N
Cardiovascular		
Arrhythmia	___	___
Chest Pain	___	___
Congenital Heart Disease	___	___
Elevated Cholesterol	___	___
Heart Attack	___	___
Heart Failure	___	___
Heart Murmur	___	___
High Blood Pressure	___	___
Heart Valve Problems	___	___
Leg Swelling	___	___
Mitral Valve Prolapse	___	___
Palpitations	___	___
Constitutional		
Fatigue	___	___
Fever	___	___
Poor Growth	___	___
Problems Sleeping	___	___
Sleep Apnea	___	___
Weight Change	___	___
Endocrine		
Diabetes	___	___
Thyroid Disease	___	___
Hematologic		
Anemia	___	___
Bleeding Problems	___	___
Blood Disorders	___	___
Swollen glands	___	___
Immunologic		
Arthritis	___	___
Hepatitis A, B, or C	___	___
HIV	___	___
Recurrent Infections	___	___
Tuberculosis	___	___

Problem	Y	N
Gastrointestinal		
Abdominal Pain	___	___
Constipation	___	___
Diarrhea	___	___
GERD (Reflux)	___	___
Gluten Sensitive	___	___
Irritable Bowel Syndrome	___	___
Nausea	___	___
Rectal Bleeding	___	___
Vomiting	___	___
Genital/Urinary		
Abnormal Menstrual Periods	___	___
Blood in Urine	___	___
Kidney Stones	___	___
Pain with Urination	___	___
Urinary Incontinence	___	___
Muscle/Bone		
Back Pain	___	___
Joint Pain	___	___
Joint Swelling	___	___
Muscle Aches	___	___
Osteoporosis/Osteopenia	___	___
Neurologic/Psychiatric		
ADD/ADHD	___	___
Anxiety	___	___
Depression	___	___
Loss of Consciousness	___	___
Migraine Headaches	___	___
Seizures	___	___
Malignancy/Cancer	___	___

If you checked yes to any of the above, is your primary care physician aware? _____