



# 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:

<u>Problem</u>	Y	N	<u>Problem</u>	Y	N
<u>Cardiovascular</u>			<u>Gastrointestinal</u>		
Arrhythmia	___	___	Abdominal Pain	___	___
Chest Pain	___	___	Constipation	___	___
Congenital Heart Disease	___	___	Diarrhea	___	___
Elevated Cholesterol	___	___	GERD (Reflux)	___	___
Heart Attack	___	___	Gluten Sensitive	___	___
Heart Failure	___	___	Irritable Bowel Syndrome	___	___
Heart Murmur	___	___	Nausea	___	___
High Blood Pressure	___	___	Rectal Bleeding	___	___
Heart Valve Problems	___	___	Vomiting	___	___
Leg Swelling	___	___			
Mitral Valve Prolapse	___	___	<u>Genital/Urinary</u>		
Palpitations	___	___	Abnormal Menstrual Periods	___	___
			Blood in Urine	___	___
<u>Constitutional</u>			Kidney Stones	___	___
Fatigue	___	___	Pain with Urination	___	___
Fever	___	___	Urinary Incontinence	___	___
Poor Growth	___	___			
Problems Sleeping	___	___	<u>Muscle/Bone</u>		
Sleep Apnea	___	___	Back Pain	___	___
Weight Change	___	___	Joint Pain	___	___
			Joint Swelling	___	___
<u>Endocrine</u>			Muscle Aches	___	___
Diabetes	___	___	Osteoporosis/Osteopenia	___	___
Thyroid Disease	___	___			
			<u>Neurologic/Psychiatric</u>		
<u>Hematologic</u>			ADD/ADHD	___	___
Anemia	___	___	Anxiety	___	___
Bleeding Problems	___	___	Depression	___	___
Blood Disorders	___	___	Loss of Consciousness	___	___
Swollen glands	___	___	Migraine Headaches	___	___
			Seizures	___	___
<u>Immunologic</u>					
Arthritis	___	___	<u>Malignancy/Cancer</u>		
Hepatitis A, B, or C	___	___			
HIV	___	___			
Recurrent Infections	___	___			
Tuberculosis	___	___			

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