Allergy Asthma Food Allergy Centers of St. Louis

Patient Name:_____ Date of Birth:_____

Food Allergy History (please complete as thoroughly as possible)

Allergy (peanut, milk, etc.)	Confirmed by allergy testing? Date? Skin and/or blood test?	First reaction (date)	Last reaction (date)	Quality of reaction (hives, wheezing, etc.)	Treatments used

Has the patient ever needed to use epinephrine? YES NO

If so, how many times and when? _____

Environmental Allergy History

Has the patient ever been diagnosed with seasonal/environmental allergies? YES NO

If YES, please complete this section.

- Which known allergens? _____
- Which medicines do you take? _____
- Has the patient ever been on allergy shots? YES NO

If NO, please complete this section.

- Do you ever have itchy eyes, a runny nose, or sneezing that is not associated with a cold or other illness? YES NO

Dermatologic History

Has the patient ever been diagnosed with atopic dermatitis (eczema)? YES NO

If YES, please complete this section.

- Which medicines have been used? _____
- How often are those medicines required? _____

If NO, please complete this section.

- Has the patient ever had an itchy rash or hives on face/arms/legs/trunk? YES NO

Respiratory History

Does the patient have any history of using albuterol (inhaler or nebulizer)? YES NO

If YES, please complete this section.

- What inhaler(s) is s/he currently using? _____
- How often does s/he use the albuterol inhaler?_____
- Has s/he been hospitalized for asthma in the last year? YES NO
- Has s/he been to the ER or urgent care for asthma in the last 6 months? YES NO

If NO, please complete this section.

- Does s/he have difficulty sleeping at night due to cough, wheezing, or any trouble breathing? YES NO
- Does s/he have difficulty running/ playing due to cough, wheezing, or any trouble breathing? YES NO
- Has s/he ever required treatment with oral steroids (prednisone/prelone/OraPred) for respiratory/breathing issues? YES NO

Gastrointestinal History

Does the patient have a history of using reflux medications? YES NO

If YES, please complete this section.

- Is s/he currently on reflux medication? YES NO
- Has s/he previously been treated with reflux medication? YES NO

If NO, please complete this section.

- Does s/he have increased burping after meals? YES NO
- Does s/he complain of burning in the chest or throat area after meals? YES NO
- Is there any history of vomiting after meals? YES NO
- Has s/he ever complained of trouble swallowing? YES NO
- Has s/he ever been diagnosed with eosinophilic esophagitis (EoE)? YES NO
- Are there any family members with eosinophilic esophagitis (EoE)? YES NO
- Does s/he complain of stomach pain? YES NO

Additional Questions

When were the patient's most recent lab studies performed? *(Please fax all available lab results to (314) 849-8737)* _____

Are the patient's immunizations up to date? YES NO

Do you have an up to date epinephrine auto-injector (ex. Epi-Pen, Auvi-Q)? YES NO