Medical History

Patient Name: _____ DOB: _____

Date: _____

1. Are you pregnant? YES / NO
2. Have you tested positive for HIV? YES/ NO
3. Have you ever had a stroke? YES / NO
4. Have you ever been diagnosed with or do you have a history of cardiovascular disease? YES / NO
5. Are you on any blood pressure medication? YES / NO
   If yes, please state which medications: _____
6. Are you on any heart medication? YES / NO
   If yes, please state which medications: _____
7. Have you ever had a severe anaphylactic reaction *(severe allergic reaction*) that required emergency medical attention? YES / NO
8. Do you have uncontrolled asthma? YES / NO
9. Within the past year have you had an allergy scratch test? YES / NO
10. Within the past year have you had Immunotherapy Medication made for you? YES / NO
11. Do you have a history of taking any allergy medications including allergy shots? YES / NO
    If yes, please state what type: _____

If there is a possibility that you are pregnant please notify the physician before you have the allergy test.

_____ _____
Patient Signature Date

Office Use Only

Provider Notes: _____
_____
_____
_____
_____

_____ _____
Physician Signature Date

Synergy Health
85 Season Lane Haiwassee Georgia 30546
706.896.0505 & Fax 866.796.2505
Version 8, 09 30 13

Allergy History

Instructions

Carefully complete in full. Accuracy and thoroughness are essential. Print all answers. Relate all answers to your own experiences, not to previous advice on skin tests. This form must be completed prior to seeing the physician. *All information will be considered confidential.*

Name _____ Street _____

City _____ State _____ Zip _____ Telephone _____

Age _____ Sex _____ Race _____ Occupation _____

Name of referring physician _____ Street _____

City _____ State _____ Zip _____ Telephone _____

When did your allergies begin? _____ (Year) How often do your allergies occur? _____ # of times per day, week, etc.)

Worse at night or day? _____ How long does it last? _____ (Hours, days, etc.)

Check months most severe:

- ☐ All months
- ☐ January ☐ April ☐ July ☐ October
- ☐ February ☐ May ☐ August ☐ November
- ☐ March ☐ June ☐ September ☐ December

What do you think makes it better?

_____

_____

_____

What do you think makes it worse?

_____

_____

_____

What do you think causes the problem?

_____

_____

_____

Check items that affect your symptoms

Irritants

- ☐ Cleanser ☐ Detergent ☐ Cooking odor ☐ Perfume
- ☐ Powder ☐ Tobacco smoke ☐ Other smoke, specify: _____
- ☐ Moth Balls ☐ Motor Fumes ☐ Paint lacquer ☐ Wax
- ☐ Glue ☐ Insect spray ☐ Fertilizers ☐ Ammonia
- ☐ Room deodorants ☐ Chemical fumes ☐ Clorox ☐ Other: _____

Toiletries

- ☐ Soap ☐ Shampoo ☐ Shaving cream ☐ Aftershave
- ☐ Spray deodorant ☐ Hair spray ☐ Hair tonic ☐ Hair dye
- ☐ Hand cream ☐ Make-up ☐ Toothpaste ☐ Denture cream
- ☐ Mouthwash ☐ Nail Polish ☐ Other: _____

Foods
☐ Milk ☐ Cheese ☐ Eggs ☐ Fish
☐ Shellfish ☐ Nuts ☐ Chocolate ☐ Alcohol
☐ Wine ☐ Beer ☐ Juices ☐ Spices
☐ Vegetables ☐ Strawberries ☐ Wheat products ☐ Very cold liquids
☐ Other: _____

Pets
Which of these do you have as pets:
☐ Dog ☐ Cat ☐ Birds ☐ Horse
☐ Hamster ☐ Rabbit ☐ Other _____
Is your condition worse around pets? ☐ Yes ☐ No
Specify: _____

Drugs
☐ Penicillin ☐ Sulfa ☐ Over-the-counter drugs, specify:_____
☐ Other: _____

Weather
☐ Hot ☐ Cold ☐ Humid ☐ Damp
☐ Pollution ☐ Smog ☐ Sunlight ☐ Air-conditioning
☐ Change in temperature

New (unwashed) Clothing
☐ Wool ☐ Silk ☐ Sweater ☐ Coat
☐ Shoes ☐ Dry-cleaned clothes ☐ Starched clothes ☐ Other:_____

Contactants
☐ Poison ivy ☐ Cut grass ☐ Cut flowers ☐ Household plants
☐ Hay ☐ Christmas trees ☐ Plastic ☐ Rubber
☐ Fiberglass ☐ Dust ☐ Wool blankets ☐ Feather pillows
☐ Mattress ☐ Furs ☐ Rugs ☐ Overstuffed furniture
☐ Rug pads ☐ Stuffed toys ☐ Jewelry ☐ Shoe polish
☐ Other: _____

Check Symptoms experienced

General
☐ Nervousness ☐ Dizziness ☐ Fainting ☐ Sinus trouble
☐ Frequent colds ☐ Fatigue ☐ Other: _____

Headache
Where? (front, back, right, left) _____
☐ Day ☐ Night
☐ Aching ☐ Throbbing ☐ Sharp ☐ Dull
☐ With vomiting ☐ Stuffy nose ☐ Better with sleep ☐ Worse with tension
☐ Spots before eyes

Cause :
☐ Migraine ☐ Food ☐ Sinus ☐ Tension
☐ Drug ☐ Other: _____

Skin
☐ Rash ☐ Hives ☐ Eczema ☐ Blisters
☐ Itching ☐ Swelling ☐ Burning ☐ Stinging
☐ Redness ☐ Perspiration ☐ Athlete's foot
Where: _____ Worse after eating? ☐ Yes ☐ No

Eyes
☐ Tearing ☐ Burning ☐ Itching ☐ Pain
☐ Redness ☐ Discharge ☐ Puffiness ☐ Infections
☐ Blurring of vision ☐ Glaucoma Other _____

Ears
☐ Pressure ☐ Itchiness ☐ Drainage ☐ Bleeding
☐ Infection ☐ Deafness ☐ Swelling ☐ Other: _____

Nose
☐ Sneezing ☐ Stuffiness ☐ Sniffles ☐ Clean running discharge
☐ Itching ☐ Cloudy discharge ☐ Snoring ☐ Difficulty in smelling
☐ Polyps ☐ Postnasal drip ☐ Bleeding ☐ Broken nose
☐ Previous Surgery ☐ Change in voice Other: _____

Tongue
☐ Swollen ☐ Sore ☐ Itching ☐ Coated
☐ Difficulty in tasting Other: _____

Mouth
☐ Itching of roof ☐ Repeated tonsillitis ☐ Tonsils removed ☐ Morning sore throats
☐ Bad breathe ☐ Swollen lip ☐ Trouble swallowing ☐ Frequent throat clearing
☐ Mouth breathing Other: _____

Mucus
☐ Thick ☐ Thin ☐ Clear ☐ Yellow
☐ Green ☐ Brown ☐ Bloody
Amount per day (teaspoon, tablespoon, ½ cup) _____
Source of mucus (nose, lungs, throat) _____

Chest
☐ Shortness of breath ☐ Wheeze ☐ Pain ☐ Tightness
☐ Cough ☐ Cough with wheeze ☐ Difficulty in walking ☐ Difficulty in working
☐ Emphysema ☐ Heart trouble ☐ High blood pressure ☐ Difficulty in sleeping
☐ Bronchitis ☐ Pneumonia ☐ Tuberculosis ☐ Cancer
☐ Other: _____

Stomach
☐ Vomiting ☐ Gas ☐ Cramps ☐ Belching
☐ Diarrhea ☐ Mucus in stool ☐ Blood in Stool ☐ Foul-smelling stool
☐ Soiling: Worse after eating what foods? _____
☐ Other: _____

Joints
☐ Pain ☐ Stiffness ☐ Swelling ☐ Other: _____

Menses
☐ Regular ☐ Irregular ☐ Discharge ☐ Itch
☐ Cramps ☐ Infections ☐ Last period (date) _____ Pain: ☐ Yes ☐ No
Are you pregnant now? ☐ Yes ☐ No Taking birth control pills: ☐ Yes ☐ No

Kidneys
☐ Pain ☐ Frequent urination ☐ Bladder infection ☐ Recurrent infection
☐ Itching ☐ Chills ☐ Fever ☐ Other: _____

Check pertinent items and fill in the blanks

Where do you live?
☐ Room ☐ Apartment ☐ Brick house ☐ Wood-frame house
☐ Mobile Home ☐ Age of House _____

Location
☐ City ☐ Suburb ☐ Country ☐ Farm
☐ Seashore ☐ Desert ☐ Mountains ☐ Near factory
☐ Near bakery ☐ Near grain storage ☐ Near swamp ☐ Near poultry yard
☐ Near barn ☐ Other: _____

Problem worse in
☐ Bedroom ☐ Living room ☐ Kitchen ☐ Basement
☐ Attic ☐ Garage ☐ Indoors ☐ Outdoors
☐ Other: _____

Type of heating
☐ Forced air ☐ Radiator ☐ Electric ☐ Heat pump
☐ Filtered air ☐ Other: _____

Problem worsens when:
☐ At home ☐ At work ☐ In car ☐ In boat
☐ Exercising ☐ Hair salon ☐ At school ☐ Driving in traffic
☐ Sweeping ☐ House cleaning ☐ Making beds ☐ Around open windows
☐ Around Humidifiers ☐ Around vaporizer ☐ Around fans ☐ Around heating
☐ On windy days ☐ Swimming in chlorinated water ☐ Taking hot or cold baths
☐ In musty places ☐ Other: _____

Insect bites or stings
☐ Large swelling ☐ Weakness ☐ Sweating ☐ Shortness of breath
☐ Stuffy nose ☐ Wheezing ☐ Other _____

Smoking habits
☐ Cigarettes ☐ Cigars ☐ Pipes
Number per day: _____ How long? (years) _____

Current Medications:
(please include dosage) _____

Place age of family members having any of the following conditions in the appropriate space:

	Father	Mother	Brothers	Sisters	Children	Other
Migraine						
Hives						
Emphysema						
Asthma						
Cystic Fibrosis						
Eczema						
Hay Fever						
Tuberculosis						
Thyroid Disease						
Glaucoma						

Unusual activities engaged in just prior to onset of symptoms

Unusual food or drink ingested just prior to onset symptoms

New environmental factors at home or at work

List any medical condition(s) for which you have been treated

List any surgery you have had

List any other conditions for which you are currently being evaluated or treated:

Physician Analysis

Clinic MRN # _____

Patient Registration

Patient Name Last: _____ First: _____ M: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

DOB: _____ SS#: _____ Gender: M / F

Employer: _____ Phone: _____

Emergency Contact: _____ Phone: _____ Relationship: _____

Primary Care Physician Name: _____ Phone: _____

Primary Insurance Information

Carrier Name: _____

Phone: _____

Claims Address:_____

_____

City: _____ State: _____ Zip:_____

Member ID: _____

Group #: _____

Insured's Name: _____

DOB: _____

Rep. Name: Ref:

Secondary Insurance Information

Carrier Name: _____

Phone: _____

Claims Address:_____

_____

City: _____ State: _____ Zip_____

Member ID: _____

Group #: _____

Insured's Name: _____

DOB: _____

Rep. Name: Ref:

Primary Verification

Effective Date: _____

Benefit Year: ☐ Calendar ☐ Fiscal
Are these benefits? ☐ In NtWrk ☐ OON
Is this a Capitated Plan? ☐ Yes ☐ No

Has there been a lapse in coverage? ☐ Yes ☐ No

If yes, is there a pre-existing clause? ☐ Yes ☐ No

Co-Insurance: _____%

Ind. Deductible $_____ Amt Met $_____

Fam. Deductible $ _____Amt Met $_____

OOP Amount: $_____Amt Met$ _____

Secondary Verification

Effective Date: _____

Benefit Year: ☐ Calendar ☐ Fiscal
Are these benefits? ☐ In NtWrk ☐ OON
Is this a Capitated Plan? ☐ Yes ☐ No

Has there been a lapse in coverage? ☐ Yes ☐ No

If yes, is there a pre-existing clause? ☐ Yes ☐ No

Co-Insurance: _____%

Ind. Deductible $_____ Amt Met $_____

Fam. Deductible $ _____Amt Met $_____

OOP Amount: $_____Amt Met$ _____