

FAMILY ALLERGY CENTER, P.C.

13890 BRADDOCK ROAD SUITE 206 • CENTREVILLE, VIRGINIA 20121-2437 • (703) 263-2333 • FAX (703) 263-0361

KENNETH R. BERGMAN, M.D.
TAMARA S. SMITH, M.D., MPH
CATHERINE THAL-LARSEN, F.N.P.

Family Allergy Center Medical History Form

Primary Care Physician: _____

Past Medical History: List any chronic health conditions or illnesses you/your child may have or have had in the past (i.e. high blood pressure, diabetes, seizures, reflux, heart trouble)

_____	_____
_____	_____
_____	_____

Past Surgical History (tonsils, appendix, ear tubes, sinus, heart, etc.)

Surgery	Year
_____	_____
_____	_____
_____	_____

Hospitalizations	Year
_____	_____
_____	_____
_____	_____

Current Medications:

Medication	Dose
_____	_____
_____	_____
_____	_____
_____	_____

Current Allergy/asthma Medications:

Medication	Dose
_____	_____
_____	_____
_____	_____

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Social History:

Occupation - _____

Do you smoke cigarettes/cigars? Yes No

How many packs per day? _____

Did you ever smoke? Yes No

When did you quit? _____

Family History: Does anyone in your family have a history of allergies (hayfever, seasonal allergy), asthma, eczema, cystic fibrosis, autoimmune disease or immunodeficiency? If so, whom?

Mother _____

Father _____

Siblings _____

Aunts _____

Grandparents _____

Cousins _____

Characteristics of Your Home:

House _____ Townhouse _____ Apartment _____ Mobile Home _____

Approximate age (years) _____

Heat Source: Gas _____ Electric _____ Wood _____ Oil _____ Other _____

Heat Delivery: Forced Air _____ Baseboard _____ Radiator _____

Air Conditioning: Central _____ Window units _____ None _____

Bedding: Crib _____ Mattress _____ Allergen covers _____

Pillow: Feather _____ Non-feather _____

Humidifier: _____

Filtration/Air Purification: _____

Daycare Attendance: Yes No

Pets (how many): Cats _____ Dog _____ Horse _____ Rabbit _____

Guinea Pig _____ Other _____