Adult & Pediatric Allergist of Central Jersey

Jayesh G. Kanuga, MD, FACAAI, FACA
Ligaya V. Centeno, MD, FACAAI
Ruby C. Reyes, MD, FACAAI
Diplomates American Board of Allergy & Immunology

1740 Oak Tree Road
Edison, NJ 08820
Tel: (732) 906-1717
Fax: (732) 906-1781

260 State Route 34
Matawan, NJ 07747
Tel: (732) 566-0066
Fax: (732) 906-1781

Initial Visit

Name: **DOB:** **Age:** **Sex Male/ Female** **Date:**

Usual Physician: _____

Pharmacy Name/ Phone #: _____

Referred by: _____

Mail Order pharmacy name and #: _____

ALL CURRENT MEDICINES Dose Frequency

_____ _____ _____ Times per day

_____ _____ _____ Times per day

_____ _____ _____ Times per day

_____ _____ _____ Times per day

_____ _____ _____ Times per day

PREVIOUS ALLERGY OR ASTHMA MEDICATIONS:

_____ □helped □no help □Side Effects: _____
_____ □helped □ no help □ Side Effects: _____
_____ □helped □ no help □ Side Effects: _____

Drug Allergies: Symptoms:

_____Caused_____
_____Caused_____
_____Caused_____

Other Allergies:

□Food:_____ □Venom_____
□Latex_____ □ Other: _____

Immunizations up to date for the age: □ Yes □ No
Immunization Adverse Reactions: □ Yes □ No

Caused?:_____

Chronic Health Conditions: Age or Year

_____Since _____
_____Since _____
_____Since _____

PAST MEDICAL HISTORY

Hospitalizations: Age or Year

____ for _____
____ for _____
____ for _____

Surgeries:
____ for _____
____ for _____
____ for _____

Birth/childhood history:
Problems present at birth □Yes □No
If Yes, Explain:_____

Frequent illness as child □Yes □No
If Yes, Explain:_____

Prior Lab Results:
_____
_____

To be completed by Nursing Staff:

Height: _____ Weight: _____

B/P: _____ Pulse: _____

ACT score: _____

Patient's Name: _____

Family History	Allergies	Asthma	Eczema	Sinus problems
Mother	□	□	□	□
Father	□	□	□	□
Brother(s)	□	□	□	□
Sister(s)	□	□	□	□
Maternal side	□	□	□	□
Paternal side	□	□	□	□
Family	□	□	□	□
Other: _____	□	□	□	□

List other chronic conditions:

_____
_____
_____
_____

Social History

Smoking:
12 yrs old and up: Are you a smoker: □Yes □ No If yes, how many years?: ____ packs/day____
What do you smoke? □ Cigarettes □ Cigars □ Pipes □ Other _____
Have you ever tried to quit smoking? □ Yes □ No Method: _____

Have you ever smoked? □Yes □No When did you quit? ____yrs How many yrs did you smoke? _____yrs
Exposed to second hand smoke? □Yes □ No

Under 12 yrs old:
Exposed to second hand smoke? □Yes □ No

Use of Recreational Drugs? □Yes □ No
Smoked_____ Intranasal_____ Other_____

Drink Alcohol? □Yes □ No
Number of drinks per week_____ □daily □occasionally □rarely □socially
Other relevant social factors:_____
How often do you consume caffeine? product: _____ #/week_____

Marital Status: _____ Living Status: □alone □with family □with friend □nursing care □other
Any children? □Yes □No How many? _____
Current occupation is: _____
Occupational exposures: _____
Hobbies:_____

CURRENT ENVIRONMENT:
Check one: □House □Apartment □Mobile home □Farm □Other_____
# of yrs in present home? □less than one year □1-5 years □more than 5 years
How old is your home? _____ Yrs Live/Work near farm? _____ type_____

	Yes/No		Yes/No	
Cats	□ □	Sleeps?: □inside	Baseboard Heat	□ □ heat type: □oil/gas □electric
Dogs	□ □	□outside□bedroom	Forced air heat	□ □ □coal □fireplace_gas __wood
Birds	□ □		Radiators	□ □
Other pets	□ □		Air conditioning	□ □
Feather pillows	□ □		Ceiling fans	□ □
Down comforter	□ □		Humidifier	□ □
Carpets or rugs	□ □		Air filter	□ □
Damp basement	□ □		Stuffed animals	□ □
Mold growth	□ □		Bookcases	□ □
			Live house plants	□ □

Comment: _____
Name of person filling out this history form (please print): _____
Relationship if not the patient: _____