Chicago Family Asthma & Allergy, S.C.
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Thank you for coming to visit us! First are details about your visit at CFAA. Please complete the rest of the form.

Patient name _____ Visit date _____ .

- **There are two entrances marked "2551" at the street level; take the *south* entrance to access our office (under the large Salon Studios awning). Dial "101" on the front security box.**
- Valet parking is available for $10 Monday-Thursday 9-5 and Friday 9-12. Metered parking is available on Clark Street. Lurie Children's Outpatient Center has a parking lot at 2515 N Clark for a fee (**WE CANNOT VALIDATE**).
- Plan to park for two (2) hours for new patient visits.
- Bring your insurance card and a form of ID. Parents, your driver's license will do for a child patient's ID.
- If your insurance requires a co-pay for your visit, you need to pay this at the time of each visit.
- If your insurance requires a referral for specialist visits (ex. HMO, some POS), please have your doctor fax it to us *prior to the visit* or bring it with you. *Without the referral, you will be responsible for payment of the visit.*
- If you may have allergy skin testing performed at your visit, **you must be off antihistamines for 5 days**. It is best to check with us or your doctor before discontinuing any medications that are important to maintain your health. Examples of common antihistamines include:

Alavert	Allegra	Astelin	Astepro	Azelastine	Atarax
Benadryl	Carbinoxamine	Cetirizine	Chlorpheniramine	Clarinex	Claritin
Clemastine	Cyproheptadine	Desloratadine	Dexchlorpheniramine	Dymista	Diphenhydramine
Doxylamine	Fexofenadine	Hydroxyzine	Levocetirizine	Levocabastine	Loratadine
Olopatadine	Patanase	Pepcid	Periactin	Pheniramine	Promethazine
Tagamet	Tripelennamine	Tripolidine	Xyzal	Zantac	Zyrtec

- **Complete the following patient history and bring it to the appointment to expedite your visit time.**

1. Summary of reason for visit:

_____
_____
_____

2. Symptom triggers (circle or complete):

Dust	Perfumes	Stress/Anxiety
Insect sting	Fumes	Fresh-cut grass
Cat	Odors	Seasons: _____
Dog	Humidity	Year-round
Other animal: _____	Air cleaners	Food: _____
Medicine: _____	Weather changes	Other: _____

3. Medications (include doses or strengths and frequency taken)

Current: _____
Medications that helped allergies: _____
Medications that did not help: _____
Any side effects or drug allergies: _____

4. Ever had allergy tests in the past? (circle) No Yes: Skin or Blood or Other
If yes, list results and bring copy to appointment: _____

5. Ever had "allergy shots"? Y or N If so, how long or during what date range? _____

6. Ever had oral corticosteroids (steroid liquid or pills)? Yes or No
If so, how many times and when? _____

7. Family history:

	Asthma	nasal allergies	eczema	food allergy	drug allergy	cystic fibrosis	immune deficiency
Mom	☐	☐	☐	☐	☐	☐	☐
Dad	☐	☐	☐	☐	☐	☐	☐
Sibling	☐	☐	☐	☐	☐	☐	☐
Aunt/Uncle	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐

List any other history of significant medical illness in family that may apply to your visit: _____
_____

8. Social history (please circle correct option):
Home: House Condo Apt New If old, age of home: _____ Recent remodeling: Yes or No
Heating: forced air radiator baseboard space heater fireplace (wood or gas)
Air conditioning: central window none Air filters: central room freestanding HEPA filter
Humidifier: No Yes: central freestanding in bedroom
Carpet: No Yes: in bedroom not in bedroom Rugs: No Yes: in bedroom not in bedroom
Dust control: dust mite coverings: No Yes: pillow mattress Pillow: synthetic feather
Comforter: synthetic feather Stuffed animals: No Yes: in bed bedroom not in bedroom
Basement: No Yes: damp or dry History of water or flood damage No Yes: fixed not fixed
Furry animals in home: No Yes: cat dog other:_____ allowed in bedroom not in bedroom
Smokers at home: No Yes: patient other outdoors indoors
Occupation, or list education level if student: _____
If patient is child, do they attend preschool or day care? No Yes: days per week: _____
Recent travel outside the United States: No Yes: when and where: _____

9. Past medical history (include pertinent dates and reasons):
Hospitalizations: _____
Surgeries: _____
Seen by other specialists: _____

10. Review of systems (circle "No", or explain if "Yes"):
General: any recent fever, weight loss or gain, other: No Yes: _____
Eyes: contacts, glaucoma, cataracts, other: No Yes: _____
Ears, nose, throat: recurrent ear infections, nasal polyps, enlarged adenoids or tonsils, other: No Yes: _____
_____
Neurologic: headache, migraines, other: No Yes: _____
Chest/respiratory: lung disease, other: No Yes: _____
Cardiovascular: heart disease, chest pain, other: No Yes: _____
Gastrointestinal: reflux, diarrhea, constipation, other: No Yes: _____
Genitourinary: bladder or kidney problems, pregnancy, other: No Yes: _____
Endocrine: thyroid disease, diabetes, other hormone disorders: No Yes: _____
Immune: recurrent infections, sinusitis, pneumonia, ear infections: No Yes: _____
_____
Skin: eczema, hives, rashes, other: No Yes: _____
Psych: anxiety, depression, stress, other: No Yes: _____
Hematology/oncology: cancer, bleeding disorder, other: No Yes: _____
Musculoskeletal: chronic conditions of joint, bone, or muscles: No Yes: _____