Illinois Allergy & Asthma Specialists

Drs. Amishi Singal Murthy and Vivian Chou
500 Davis St • Suite 512 • Evanston, IL 60201
3000 N Halsted St • Suite 724 • Chicago, IL 60657
Phone (847) 328-7909 • Fax (847) 328-7919
www.ilallergyasthma.com

Welcome! Please email completed forms to at ilallergyadmin@myupdox.com or bring it to your visit.

PATIENT NAME: _____ DATE OF BIRTH: _____

- **See the "Locations" tab on our website for location and parking details.**
- Office visits may take up to **one (1) hour** for new patient visits.
- **Bring your current insurance card and a form of identification**. (Parent ID for child<18 years old).
- If your insurance requires a **co-pay** for your visit, you must pay this at each visit (Visa or Mastercard).
- If your insurance requires a **referral** for specialist visits, please have your primary care doctor send it to us ***prior to the visit or bring it with you*, or *you will be responsible for payment of the visit.***
- **For skin testing, the patient should not take antihistamines for at least seven (7) days prior to the visit.**
- ****PLEASE refer to the attached MEDICATION TO STOP list***

Briefly, what is the reason for your visit?

_____
_____
_____
_____

What triggers your symptoms?

□ Spring season □ Summer □ Fall □ Winter □ Year-round □ Seasonal change

□ Dust □ Pollen □ Cat □ Dog □ Scent or perfume □ Mold

□ Cigarette smoke □ Humidity □ Viral illness □ Exercise □ Nighttime

□ Other:

_____
_____

Please list current medications and/or vitamins you/the patient take: (Please include dosages and frequency. Also please feel free to bring them with you to your visit if you like.)

_____
_____
_____
_____
_____
_____

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Medication allergies:

□ None
List allergies and reactions:

_____

_____

PAST MEDICAL HISTORY:
Please list any past surgeries:

_____

_____

Please list any past hospitalizations:

_____

_____

Please list any visits to the emergency room:

_____

_____

Please list any medical issues:

_____

_____

_____

_____

FAMILY HISTORY (check any that apply):

	Asthma	Allergic rhinitis (hay fever)	Eczema	Food Allergy	Immune deficiency	Hives/swelling
Parent #1						
Parent #2						
Sibling						
Child(ren)						

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Other significant medical illness in the family: If deceased, please list cause of death:

SOCIAL HISTORY:

Household members?

Do you or anyone in your home smoke tobacco? How many packs per day and for how many years?

Are there any pets at home? If yes, how many?

Does your home have carpeting? (Please indicate the rooms that have carpeting):

Has your home experienced any mold or water damage? Has it been resolved?

Please state your occupation:

Does the patient attend daycare/school? If in school, which grade?

Please state hobbies/sports that the patient participates in:

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REVIEW OF SYSTEMS: (please circle those that apply)

Fevers	Chills	Unexpected weight loss /gain	
Itchy watery eyes	Nasal congestion	Runny nose	Postnasal drip
Sinus pressure/pain	Loss of smell	Bloody nose	Sore throat
Eye pain with bright light vision changes		Contact/glasses	Cataract
Glaucoma	Chest pain	Heart murmur	Fatigue
Heart palpitations (irregular heartbeat)		High blood pressure	Cough
Wheeze	Shortness of breath	Exercise intolerance	Nausea
Vomiting	Abdominal pain	Constipation	Diarrhea
Heartburn	Joint pain	Swollen joints	Autoimmune illness
Heat or cold intolerance	Thyroid issues	Diabetes	Depression
Anxiety	ADHD	Bipolar	Migraines
Headache	Dizziness	Numbness	Tingling
Rash	Hives	Swelling	Eczema
Frequent or recurrent infections		Frequent antibiotics	

Patient/Guardian signature: _____ Date: _____