ID#_____

New England Food Allergy Treatment Center Medical History Form

Patient Name: _____Sex:_____ D.O.B: _____/_____/_____

Do you see an allergist? Circle: **YES or NO**	Primary Care Doctor:
Name/Address:_____ _____ _____ Most recent visit:_____	Name/Address:_____ _____ _____ _____

Allergy History: Please list foods you are allergic to:
_____

Have you/your child ever had an allergic reaction? Circle: YES or NO

If yes, to what food/foods? _____

Please describe reaction/reactions:
_____
_____
_____
_____
Date of reaction/reactions:_____
Treatment given:_____
How much allergen was eaten? _____

Skin tested to allergen? Circle: **YES or NO** Date: _____ Result: _____

Date of most recent blood test: _____
Result/if known: _____ (if not, please contact your doctor)

Oral Challenge? Circle: **YES or NO** Result: _____

Allergic History: (Symptoms, triggers, current treatment, date of onset/diagnosis)
All Food Allergies/to what_____
_____
_____

Asthma: _____
Allergic Rhinitis: _____
Atopic Dermatitis (Eczema): _____
Drug/Insect Allergy: _____

Please circle which medication used: **EpiPen / EpiPen Jr. / Auvi-Q / Auvi-Q Jr.**
Date expires: _____ (If expired, please ask for a prescription)

Significant Medical History: _____
_____
_____

Family History of allergy (Immediate family members):_____
_____

All Current Medications:

Medication	Dose	Indication

If asthma history, please describe (onset/treatment/duration): _____
_____
_____

Are symptoms greater than twice a week or continuous? Circle: **YES** or **NO**
If yes, please describe frequency: _____
_____

Circle Symptoms: Coughing / Chest Tightness / Wheezing / Shortness of Breath

If available, Peak Flow: _____ AM(pm)/_____ PM(pm)
Personal best PF: _____

Nighttime symptoms? Circle: **Always / During Exacerbations Only / Never**
Exercise symptoms? Circle: **Routine Activities / Vigorous Exercise / None**

ER visit or hospitalizations in the past 6 months? Please describe: _____
_____
_____