



ALLERGY & ASTHMA
CENTER OF TEXAS

John B. Meiser, M.D., P.A.

Today's Date: ____ / ____ / ____

Health Information Sheet

Patient's Name: _____ Date of Birth: _____ Age: _____

Primary Care Physician: _____

How were you referred to Dr. Meiser? _____

Pharmacy name: _____ Location (City and Cross Streets): _____

Please describe the reason for the visit today: _____

Past Medical History – Please list **ALL** past medical problems:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Past Surgical History – Please list all past surgeries and the date that they were performed:

1. _____ 3. _____

2. _____ 4. _____

Allergy History – Are you allergic to any **food, medicine, chemical, latex, insects, and/or other?** YES NO

If yes, please list: _____

Family History – Please list medical problems experienced by patient's family members: (Include allergy/asthma/eczema/immune problems)

Mother's Side: _____

Father's Side: _____

Social History – Please answer the following questions:

Do you have pets? NO YES If yes, what type and how many? _____

Do you currently smoke or have you smoked in the past? NO YES If yes, how long? _____

Do you consume alcohol? NO YES If yes, how many drinks per week? _____

Do you exercise? NO YES If yes, what type of exercise? _____ How often? _____

Are you exposed to mold/fumes/strong odors/chemicals? NO YES If yes, where/what? _____

Review of Systems – Please circle any signs/symptoms/conditions that you currently experience:

- Chest:** fast heart rate palpitations
- Constitutional:** chills fatigue fever night sweats
- Ears:** discharge ear congestion ear itching earache hearing loss vertigo
- Mouth and Throat:** dry mouth sore throat
- Endocrine:** cold intolerance heat intolerance increased thirst weight gain weight loss
- Eyes:** blurred vision itch redness watery
- Frequent infections:** bronchitis ear (otitis) pneumonia sinusitis skin
- GI:** diarrhea heartburn reflux trouble swallowing vomiting
- Hematology:** swollen lymph nodes unusual bleeding unusual bruising
- Musculoskeletal:** muscle pain red/swollen joints stiff/sore joints
- Neurologic:** headaches numbness weakness
- Nose:** congestion itch loss of smell runny sneezing snoring
- Psychology:** anxious depressed stressed
- Respiratory:** cough croup shortness of breath tight chest wheeze
- Sinus:** pain post nasal drip pressure
- Skin:** dry hives itch rash swelling

Current Medication – Please list current medicines including **dose and directions.** (Over the Counter, prescription medicine and herbal remedies)

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____