



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. \_\_\_\_\_