Hanissian allergy
breathe better

a division of consolidated medical practices of memphis, pllc

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Patient Name: _____ Birth Date: ___/___/___ Today's Date: ___ /___ / ___

Referring Physician: _____ Referring Physician Location: _____
Pharmacy Name: _____ Pharmacy Phone Number: ( ) _____ - _____

Reason For Today's Visit: _____
Please describe this problem: _____
_____

PRIOR SURGERIES	DATE of SURGERY	CURRENT ILLNESSES OR INJURIES

Please list ALL medications (prescription & non-prescription). Please include OTC medications & any blood thinners like aspirin.

MEDICATION	DOSE	MEDICATION	DOSE

Do you have any drug allergies or intolerances? [ ] NO [ ] YES

ALLERGY	TYPE	REACTION

Do you have any insect, food, or contact allergies (e.g. wasp, adhesives, sunscreen, peanuts, shrimp)

ALLERGY	TYPE	REACTION

Do you smoke? [ ] No & Never Have [ ] Former (quit) [ ] Current Socially Only [ ] Current Daily

Type of smoke (cigarette, cigar, pipe)	How Much Per Day Did or Do You Smoke?	For How Long?

Do you have pets? [ ] No [ ] Yes How many of each? Dogs___ Cats___ Other Furry Pets _____ (what kind?)

Please describe any health issues in family members (below):

FAMILY MEMBER	CONDITIONS	FAMILY MEMBER	CONDITIONS
Mother		Mat. Grandmother	
Father		Mat. Grandfather	
Brother		Pat. Grandmother	
Sister		Pat. Grandfather	

Do you have other complaints (examples: cough, shortness of breath, fever, weight loss, joint pain, headache, diarrhea, etc.)

_____
_____

Patient (or parent/guardian) Signature: _____ Physician Signature: _____