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Medical & Allergy History Form

Please Print

Today's Date: _____ /_____ /_____

Patient Name: _____ (Last), _____ (First), _____ (M.I.)

Sex: ☐ Male ☐ Female Date of Birth: _____ (Month) /_____ (Day) /_____ (Year) Age: _____ Drug Allergies:_____

Most Bothersome Symptom(s)

Surgical History

Date	Operation

Current Medications (including vitamins & supplements)

Medication Name	Frequency

Past Medical History

Check all that apply

- ☐ Allergies (to: _____)
- ☐ Asthma
- ☐ Bleeding Tendencies
- ☐ Cancer
- ☐ Cholesterol
- ☐ Gastrointestinal (i.e., stomach ulcers, reflux, etc.)
- ☐ Glaucoma
- ☐ Immunodeficiency
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Sinus (nasal surgery, polyps)
- ☐ Skin (hives, rashes, etc)
- ☐ Emphysema
- ☐ Other:
- ☐
- ☐
- ☐

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Patient Name: _____ (Last), _____ (First), _____ (M.I.) Date of Birth: _____ (Month) /_____ (Day) /_____ (Year)

What concerns bring you in today? Please select all that apply.

Skin Concerns	
Eczema	☐
Hives	☐
Ear Concerns	
Hearing loss	☐
Fluid	☐
Infection/pain	☐
Itching	☐
Popping	☐
Throat Concerns	
Sore/drainage	☐
Itching throat/mouth	☐
Eye Concerns	
Redness	☐
Itching	☐
Tearing	☐
Puffiness	☐
Nose Concerns	
Clear discharge	☐
Thick, colored discharge	☐
Itching/rubbing	☐
Constant stuffiness	☐
Sniffles	☐
Sneezing	☐
Mouth breathing/snoring	☐
Chest Concerns	
Wheezing/colds	☐
Wheezing when exposed to dust, pollen, animal, etc.	☐
Wheezing/cough after exercise	☐
Cough Type	
Deep/productive	☐
Loose	☐
Constant	☐
Dry/tight	☐
Daytime	☐
Nighttime	☐
Symptoms	
Mild	☐
Moderate	☐
Severe	☐
Present most of the time	☐
Present some of the time	☐
Present rarely	☐
Interfering with your life	☐
Preventing normal activities	☐

In your opinion, what aggravates your symptoms?

Pastimes & Life at Home

Do you smoke?

	Daily	Weekly	Monthly	Never
Cigarettes	☐	☐	☐	☐
Cigars	☐	☐	☐	☐
Marijuana	☐	☐	☐	☐
Shisha/Hookah	☐	☐	☐	☐
Vaping/E-Cig (etc.)	☐	☐	☐	☐
Smokers at home	☐	☐	☐	☐

Other - specify

If you do smoke, how long have you smoked?

If you quit smoking, when did you quit?

At home, do you have a...

	0	1	2+
Bird	☐	☐	☐
Cat	☐	☐	☐
Dog	☐	☐	☐
Rodent	☐	☐	☐
Other - indicate & specify	☐	☐	☐

If no, have you ever had animals at home?
please specify

Is Your Home...

New	☐
3-10 Years Old	☐
11-25 Years Old	☐
>25 Years Old	☐
I don't know how old my home is	☐

Do you live in... (please check all that apply)

An Apartment	☐
A Condo	☐
A House	☐
The City	☐
The Suburbs	☐

FRM_009 Rev 1G MAHF - January 2020