Midwest Immunology

Initial History Form

Name: ___________________________________
DOB:___________________________________

Physicians involved in your care along with clinic name:_______________________________________
____
____

Reason for Immunology Referral:____
____

Current Medications along with dosage and frequency, including over-the-counter medications:____
____
____

Drug Allergies:____
____

Latex Allergy? **Yes**_____ **No**_______

Environmental Allergies (grass, dust, mold, etc.):____
____
____

Hospitalizations (list most recent first):____
____

Surgeries:____
____

Social History:

Occupation:____

With whom do you live?:____

House, apartment, trailer home?:_________________________________

Pets in the home?:____

Smoke exposure?:____

Chemical or fume exposure?:_____________________________________

Previous blood transfusion?:_____________________________________

Family History (recurrent infection, rheumatoid arthritis, asthma, diabetes, etc.):

Siblings:____

Mother:____

Father:____

Maternal grandmother:____

Maternal grandfather:____

Paternal grandmother:____

Paternal grandfather:____

Children:____

Other:____

Do you have now or ever had any of the following symptoms: (circle if yes)

Hair loss
Scalp sores
Hearing loss
Ear drainage
Eye irritation
Drainage from eyes
Blurred vision
Mouth sores
Dental decay
Tooth loss
Sinus infection
Neck stiffness

Wheezing
Shortness of breath
Cough
Sputum production
Chest pain
Heart palpitations
Nausea
Acid reflux
Abdominal pain
Diarrhea
Constipation
Swelling of joints

Joint pain
Urinary tract infections
Menstrual irregularities
Skin rashes
Eczema
Delayed healing

Other pertinent medical information:____

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- Please bring all related medical information to your appointment or have it faxed to Midwest Immunology prior to your appointment. (763) 577-7553