BRIAN E. NOVICK, M.D.
BOARD CERTIFIED, PEDIATRIC AND ADULT ALLERGY/IMMUNOLOGY

Patient Name:_____ Date:_____
Date of Birth:_____

Dear Patient:
We want your visit at our office to be a positive experience. To help make that happen, we are hoping you can complete this form before your visit. Please answer the questions below and bring this form with you on your appointment day. Thank you in advance for your cooperation.

Chief Complaint_____

1. Please tell us briefly why you are coming for an allergy evaluation:_____
_____

2. Does anyone in your immediate family have a **history of allergies or asthma?** Y___ N___ Who?_____

3. Do you **Smoke?** Y___ N___ How long?____ How Much?_____ If an **ex-smoker,** when did you quit?
Are there other smokers in the home? Y__ N__ Are you exposed to smoke? (ie., Family/friends/co-workers)_____

4. Do you have any **pets** at home? Y____ N____ If yes, please list them_____
If yes, do they have access to your bedroom? Y____ N____

5. As far as you know, are you **allergic to any medications?** Y____ N____ If yes, please list them_____
_____

5a. As far as you know, are you **allergic to any foods?** Y____ N____ If yes, please list them_____
_____

6. Have you ever had a **severe reaction** after eating any **food**? (difficulty breathing? Hives all over the body?)
Y____ N____ If yes, please list the food and briefly describe the incident
_____

7. Is your bedroom **carpeted?** Y____ N____. Are your pillows **feather** or **synthetic**? **(Please circle one).**

8. What is your **occupation?**_____. Do you work **inside** or **outside**? **(Please circle one)**.

9. Please list any **past or current medical problems** and **surgeries** _____
_____

10. Please list all **medications** you are taking **regularly**_____
_____
If you need more room for any answer, please feel free to write on the back of this page.

MD Signature_____ #preptinfo

www.allergytestingcenter.com
118-21 QUEENS BLVD., SUITE 601, FOREST HILLS, NY 11375 TEL.: 718-261-3663 FAX: 718-261-2285