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Bel Air, MD 21015
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Matthew P. Mardiney, MD
ADVANCED
ALLERGY & ASTHMA
CENTERS

Towson/Lutherville
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Lutherville, MD 21093
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New Patient Medical History

PLEASE PRINT

Name: _____ Date of Birth: _____ Date of 1st Visit: _____

How did you hear about us:

☐ Primary care Physician _____ ☐ Friend/Relative _____

☐ Radio ☐ Internet ☐ Insurance ☐ Newspaper

Who are your doctors? Primary Care: _____ Other: _____

Pharmacy info: Name_____ Phone Number _____

Address: _____

Information provided on this questionnaire will be of major assistance to the doctor in helping you. Base your answers on your own observations, not on what you have heard by others or based on previous allergy tests.

What brings you to Advanced Allergy and Asthma Centers?

_____

_____

Past Medical History:

☐ Acne	☐ Ear Problems	☐ Kidney Disorder
☐ AIDS/HIV	☐ Eating Disorder	☐ Kidney Stones
☐ Anaphylaxis	☐ Eczema	☐ Liver Disorder
☐ Alcoholism	☐ Epilepsy	☐ Lung Disease
☐ Allergies	☐ Gallstones	☐ Nasal Polyps
☐ Anemia	☐ GERD/Heartburn	☐ Osteoporosis
☐ Anxiety	☐ Glaucoma	☐ Pneumonia
☐ Arthritis	☐ Gout	☐ Rheumatic Fever
☐ Asthma	☐ Hay Fever	☐ Sinusitis
☐ Back Problems	☐ Headaches	☐ Skin Disorder
☐ Blood Disorder	☐ Hepatitis B	☐ Sleep Apnea
☐ Blood Transfusion	☐ Hepatitis C	☐ Stroke
☐ Bronchitis	☐ High Blood Pressure	☐ Substance Abuse
☐ Cancer	☐ High Cholesterol	☐ Thyroid Problem
☐ COPD	☐ Hives	☐ Tuberculosis
☐ Diabetes	☐ Joint Disorder	☐ Sexually Transmitted Infection

Other: _____

When do your symptoms occur? (please circle)

Winter Spring Summer Fall All Seasons

Are your symptoms worse: (please circle)

At Home At Work At School On Vacation

Have you ever had an allergy skin test?

☐ Yes ☐ No When? _____

Have you ever had allergy blood test?

☐ Yes ☐ No When? _____

Have you ever had allergy shots?

☐ Yes ☐ No When? _____

Do you have any food allergies?

Food(s): _____

Reaction: _____

Medications:

What medications are you currently taking?

Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency
Name	Dose	Frequency