Premier
ALLERGY, ASTHMA & SINUS CARE
2073 N. Clybourn Ave., Chicago, IL 60614 T 773.665.4016 / F 773.360.6200

Board Certified
Allergy and Immunology
John G. Latall, MD

Today's Date: _____

Guardian Name (if minor): _____

Patient Name: _____

Social Security Number: _____

DOB: _____

Gender: ☐ **Male** ☐ **Female**

How were you referred?

_____

Contact Information

Home	Address: _____ _____ _____	Phone number: Home: _____ Cell: _____ Other: _____	E-mail: _____ _____ _____
Work/Employer	Name and Address: _____ _____ _____ _____	Contact: Phone: _____ Fax: _____	E-mail: _____ _____ _____

Emergency Contact Information	**Primary Care Physician Information**	**Pharmacy Information**
Name:	Physician Name:	Name:
Phone number:	Phone number:	Phone number:
Relationship to you: _____ _____	Clinic Name and Address (approximate location ok) _____ _____	Address: (approximate location ok) _____ _____

Insurance Information

Primary Insurance Carrier:	Secondary Insurance Carrier:
Name of Insurance Policy Holder:	Name of Insurance Policy Holder:
DOB of Insurance Policy Holder	DOB of Insurance Policy Holder:
Subscriber ID:	Subscriber ID:
Group Number:	Group Number:
Provider/Customer Service Phone Number (listed on back):	Provider/Customer Service Phone Number (listed on back):

Reason for referral/visit:

_____

_____

_____

Previous skin testing? When: _____ Where: _____

Please list all current medications with dosage you are taking (please include all, prescription, over-the-counter medications, nasal sprays, eye drops, topical creams/ointments, vitamins, and birth control):

_____

_____

_____

Have you ever had a suspected allergic reaction to any MEDICATIONS in the past? If so, please list below:

Medication/reaction/year: _____	Medication/reaction/year: _____

Have you ever had a suspected allergic reaction to any FOODS in the past? If so, please list below:

Food/reaction/year: _____	Food/reaction/year: _____

Please list any chronic medical conditions or health problems you have had (include acid reflux, high blood pressure, diabetes, thyroid disorders, cancer, etc)

_____

Please list any past surgeries you have had with the approximate date: (include tonsils/adenoid removal, gallbladder removal, and appendix removal)

_____

Please mark an "X" where appropriate:

Family History	Environmental Allergies	Food Allergies	Asthma	Hives/ Swelling	Eczema/ Itchy/Dry Skin	Other (please list thyroid disease, high blood pressure, diabetes, etc)
Mother						
Father						
Brothers						
Sisters						

Social History:

Do you currently smoke? □ Yes □ No	Are you currently employed/in school? □ Yes □ No Occupation/School: _____

Environmental History

Type of residence: □ Apartment □ House □ Other:	Number of years living in Chicago/Chicagoland Area? If recently moved, past residence?
Type of flooring in home: □ Carpeting □ Hardwood floor □ Other:	Any indoor pets? □ Yes □ No If yes, please list type of pets and how many:
Visible mold or water damage in your home? □ Yes □ No	History of flooding in your residence? □ Yes □ No
Use of dust covers encasings on mattress or pillows? □ Yes □ No	Use of HEPA filter in your home? □ Yes □ No

The information that I have written /filled in above is true to my knowledge.

_____ _____

Patient Signature (or Responsible Party) **Date**