

**Anh-Dai K. Nguyen, MD**  
**Family Allergy & Asthma Associates**  
 Board Certified in Pediatric and Adult Allergy & Immunology  
 19465 Deerfield Ave, Ste. 301, Lansdowne, VA 20176  
 (703) 729-1723  
 (703) 444-7201 Fax

<b>Name:</b>	<b>Date of Birth:</b>	<b>Date:</b>
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**Primary Care Doctor:** \_\_\_\_\_ **Referring Doctor:** \_\_\_\_\_

**Reason for Visit:** \_\_\_\_\_

**Preferred Pharmacy (Name and city)** \_\_\_\_\_ **Pharmacy Phone number** \_\_\_\_\_

**Any Known Drug Allergies:**  **No**  **Yes, list medications and reactions**


**Medications: (List all current medications)**

<b>Medication</b>	<b>Reason for Taking</b>

**Social History**

Occupation:
Marital Status:
Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No      How much? <span style="float: right;"><b>How long?</b></span>
Does anyone in the home smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No

**Environmental History**

How old is your home?
Do you have a basement? <input type="checkbox"/> Yes <input type="checkbox"/> No      Does it get damp? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have a humidifier? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have an air conditioner? <input type="checkbox"/> Yes <input type="checkbox"/> No
Do you have carpeting in the bedroom? <input type="checkbox"/> Yes <input type="checkbox"/> No
Are there any pets in the home? <input type="checkbox"/> Yes <input type="checkbox"/> No <b>Type:</b>

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**Past Medical History**

<input type="checkbox"/> Allergies	<input type="checkbox"/> Dizziness	<input type="checkbox"/> HIV
<input type="checkbox"/> Anemia	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Lupus
<input type="checkbox"/> Asthma	<input type="checkbox"/> Eczema	<input type="checkbox"/> Migraine Headache
<input type="checkbox"/> Aids	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Esophageal Reflux	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Chronic Obstructive Pulmonary Disease	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Cystic Fibrosis	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Stroke Syndrome
<input type="checkbox"/> Diabetes Mellitus	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Thyroid Disorders
<input type="checkbox"/> Other		

**Family History**

	Family History	Father	Mother
Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Asthma	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Insect Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Food Allergies	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Eczema	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Hives	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Immunodeficiency	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes
Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes	<input type="checkbox"/> Yes