

# Allergy Consultants, P.A.

Specialists in Pediatric and Adult Allergy, Asthma, and Sinus Disease

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## MEDICAL HISTORY FOR FOREIGN TRAVEL

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

Travel Plans \_\_\_\_\_

List all medical conditions:

List any medications taken in the past week (including aspirin and vitamins):

List all hospitalizations/ER visits:

List any reactions/allergies to medications:

List any reactions you have had to foods:

List any reactions to bee/insect stings:

Please check any additional problems you are expecting:

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Depression      | <input type="checkbox"/> Fatigue            | <input type="checkbox"/> Visual Changes | <input type="checkbox"/> Hearing Problems  |
| <input type="checkbox"/> Throat Problems | <input type="checkbox"/> Breathing Problems | <input type="checkbox"/> Chest Pain     | <input type="checkbox"/> Palpitations      |
| <input type="checkbox"/> Heartburn       | <input type="checkbox"/> Bladder Problems   | <input type="checkbox"/> Seizures       | <input type="checkbox"/> Muscle Aches      |
| <input type="checkbox"/> Joint Pains     | <input type="checkbox"/> Rash               | <input type="checkbox"/> Itching        | <input type="checkbox"/> Bleeding Problems |

### Family History

Father \_\_\_\_\_

Mother \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

Children \_\_\_\_\_

Type of work/daily activity

- Office setting       Outdoors setting       Homemaker       School

Do you smoke:       Yes       No      How much?

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