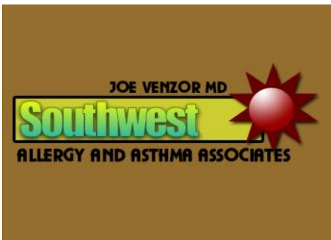

Welcome!

Joe Venzor MD
11410 Vista Del Sol
El Paso, Texas 79936
(915)592-6269

Patient Information **Date**________________

Name:____________________________________ I When did you move to El Paso__________________________
Referring Doctor:____________________________I Referring Patient:______________________________________
Phone (___)_________________ Work Phone (___) _________________ Cell Phone (___)____________________

Chief Complaint: ____
Date Symptoms Began: ____

Are you having: ☐ Hives ☐ Eczema ☐ Swelling ☐ Dermatitis ☐ Drug reaction
Where is your rash? ____
What do you think is causing your rash? _________________________ ____________________________________
How long does the rash last? ☐ Minutes ☐ An hour ☐ Hours ☐ Days ☐ Months ☐ Years
What time of the day is your rash worse: ☐ Morning ☐ Afternoon ☐ Evening ☐ Night ☐ All the time

Any new foods, medications or products since the rash started? ____
☐ Prior hives ☐ Prior eczema

Is your rash worsened by the following?
☐ Soap ☐ Detergent ☐ Shampoo ☐ Lotion ☐ Perfumes ☐ Stress ☐ Vaccinations
☐ Heat ☐ Cold ☐ Pressure ☐ Water ☐ Contact with latex ☐ Contact with metal ☐ Contact with rubber
☐ Foods ☐ Nut products ☐ Seafood ☐ Beer or wine ☐ Medications___________________________________

Any other doctors who have seen you for this condition: ____

Laundry Detergent used: ____
Lotion used and how often applied: ____
Bathing soap used: ____

Do you have?
☐ Dogs ☐ Cats ☐ Birds ☐ Feather pillow ☐ Down comforter
☐ Thyroid disease ☐ Kidney problems ☐ Liver disease

Current Medications

Medication Name	Dosage	Started when	Reason for use	How many times a day

Previously used medications:	☐ Claritin	☐ Allegra	☐ Zyrtec	☐ Hydroxyzine	☐ Cyproheptadine	☐ Doxepin
Previously used medications:	☐ Cetirizine	☐ Carbinoxamine	☐ Prednisone	☐ Steroid injection	☐ Singulair	
Previously used medications:	☐ Elidel	☐ Protopic	☐ Locoid	☐ Dermatop	☐ Triamcinolone	☐ Diprolene
Previously used medications:	☐ Clobetasol	☐ Mometsone	☐ Temovate	☐ Hydrocortisone butyrate	☐ Westcort	

Past Medical History

Medical problems____

Past surgeries ____

Hospitalizations ____

Drug allergies ____

Family History - Does anyone in your family have:

Mother	☐ Allergy	☐ Asthma	☐ Hives	☐ Chronic sinusitis	☐ Eczema
Father	☐ Allergy	☐ Asthma	☐ Hives	☐ Chronic sinusitis	☐ Eczema
Siblings	☐ Allergy	☐ Asthma	☐ Hives	☐ Chronic sinusitis	☐ Eczema
Grandparents	☐ Allergy	☐ Asthma	☐ Hives	☐ Chronic sinusitis	☐ Eczema

Do you smoke? ___________________Have you ever smoked? _____________________How long?______________

Do you drink alcoholic beverages? ____

What is your occupation? ____

What are your hobbies? ____

Allergy History

☐ Nasal congestion	☐ Runny nose	☐ Sneezing	☐ Clearing throat	☐ Itchy nose
☐ Chronic sinusitis	☐ Bad breath	☐ Loss of smell	☐ Headaches	☐ Snoring
☐ Cough	☐ Asthma	☐ Shortness of breath	☐ Chest tightness	☐ Wheezing
☐ Eye watering	☐ Eye itching	☐ Ear pain	☐ Sore throat	

Have you ever been tested for allergies and where? ____

Review of symptoms

☐ Fever	☐ Weight loss	☐ Night sweats	☐ Joint pains	☐ Jaundice
☐ Fatigue	☐ Dizziness	☐ Frequent infections	☐ Painful urination	☐ Dark urine
☐ Heartburn	☐ Easy bruising	☐ Are u always cold?	☐ Constipation	☐ Fatigue