Name: _____ Date: _____

How were you referred?

- ❑ Physician _____
- ❑ Other _____
- ❑ Self Referral

What problem brings you or your child to this appointment? _____

_____

_____

What did the symptoms begin? _____

Are your symptoms getting worse? Circle: Yes or No.

Do you have any of the following symptoms? Please check all that apply.

❑ Cough	❑ Runny Nose	❑ Nasal Polyps	❑ Eczema
❑ Wheezing	❑ Nasal Congestion	❑ Poor Sense of Smell	❑ Hives/Swelling
❑ Shortness of Breath	❑ Itchy Nose	❑ Ear Infections	❑ Headaches
❑ Chest tightness	❑ Itchy / Watery Eyes	❑ Sinus Infections	❑ Snoring
❑ Sneezing	❑ Postnasal Drip	❑ Blocked Ears	❑ Fatigue
❑ Phlegm / Sputum:	Color_____		❑ Other

Which of the following trigger (or cause) the symptoms. Please check all that apply.

❑ Grass	❑ Dogs	❑ Perfumes	❑ Pollution
❑ Hay	❑ Horses	❑ Insecticides	❑ Exercise
❑ Mold & Mildew	❑ Other animals	❑ Odors	❑ Nervousness
❑ Basements	❑ Alcoholic Beverages	❑ Drafts	❑ Cold Air
❑ Leaves	❑ Cosmetics	❑ House dust	❑ Humidity
❑ Cats	❑ Aerosol sprays	❑ Smoke	❑ Weather Changes
❑ Latex (rubber)	❑ Other: _____		

When are your symptoms worse?

❑ Year Round			
❑ January	❑ February	❑ March	❑ April
❑ May	❑ June	❑ July	❑ August
❑ September	❑ October	❑ November	❑ December

Are symptoms better away from home? Circle: Yes or No. If yes, when? _____

Have you been skin tested? Circle: Yes or No.
Results: _____

Have you had allergy injections? Circle: Yes or No. If yes, when? _____
Have you received drugs such as cortisone, prednisone, methyl prednisone, etc.? Circle: Yes or No.
When? _____ How much? _____

Occupation (current or previous): _____

Any harmful exposure at work or school? _____

Environmental Survey

How long have you lived in your house/apartment? _____
Approximately how old is your house/apartment/condo? _____

Do you live in a: ❑ House ❑ Apt / Duplex ❑ Condo / Town House
Do you live ❑ In the city ❑ In the suburbs ❑ Rural areas

Do you have a basement? ❑ Yes ❑ No
Is your house built on a slab? ❑ Yes ❑ No

Type of heating system? ❑ Hot Air ❑ Steam (radiator) ❑ Electric ❑ Hot water baseboard

Do you use a: ❑ Humidifier ❑ Wood/Coal Stove ❑ Dehumidifier ❑ Air Cleaner

Of Pets? Indoor or Outdoor? ❑ None ❑ Cats ❑ Dogs ❑ Birds ❑ Other

Are there any tobacco smokers in your house? ❑ Yes ❑ No
Is your bedroom in the basement? ❑ Yes ❑ No
Do you have allergy proof encasing for pillow or mattress ❑ Yes ❑ No

What type of pillow do you have? _____
What type of comforter do you have? _____
What type of floor covering do
you have in your bedroom? ❑ Wall to wall ❑ Area rug ❑ Animal skin ❑ Bare floor

How old is your mattress? _____ What is in your mattress? (I.e. cotton, horsehair, etc.) _____

Do you have air conditioning? ❑ Yes ❑ No If yes, ❑ Window Unit ❑ Central

Do you have problems with roaches or mice? ❑ Yes ❑ No
Do you have water leaks, mold contamination? ❑ Yes ❑ No
Is your home/apartment excessively humid? ❑ Yes ❑ No

Your Past Medical History

Check all that apply:

❑ Diabetes	❑ Liver disease/hepatitis	❑ Peptic	❑ Heartburn/reflux
❑ Cancer	❑ Heart problems/murmur	❑ Thyroid disease	❑ Seizures
❑ High blood pressure	❑ Osteoporosis	❑ Arthritis	❑ Migraines
❑ Anemia/Blood Disorder	❑ Kidney/bladder Disease	❑ Hay fever	❑ Depression
❑ Asthma	❑ Glaucoma	❑ Diarrhea	❑ Anxiety
❑ Back problems	❑ Emphysema	❑ Cataracts	❑ Loss of hearing
❑ PMS	❑ Endometriosis	❑ Infertility	❑ Menopause

If yes to any of the above, please explain: _____

_____

_____

Have you had your tonsils or adenoids removed? ❑ Yes ❑ No

Have you had ear, nose or sinus surgery? ❑ Yes ❑ No

If yes, please explain: _____

_____

Do you smoke now? ❑ Yes ❑ No How Much? _____ # Of years? _____

Have you smoked before? ❑ Yes ❑ No When did you stop? _____ # Of years? _____

Family History

Who in your family has had?

Asthma _____

Eczema _____

Seasonal or Year Round Allergies _____

Other Allergies (drugs/bees/food etc) _____

Sinus Problems _____

Please list any hospitalizations regardless of cause: _____

_____

_____

List any food allergies and reactions experienced: _____

_____

List any drug allergies and reactions experienced (i.e. penicillin, aspirin, sulfa, latex, etc): _____

_____

Describe any reaction to insect stings: _____

_____

List all medications & dosages (including nasal sprays, non-allergy medications, alternative/herbal products):

_____

_____

_____

Patient Name: _____ Clinic #: _____

Date: _____ Questionaire Reviewed: _____

Food Allergy Section:

Check any symptoms that you have experienced:

- ❑ Abdominal cramping
- ❑ Anaphylactic shock
- ❑ Arthritic type symptoms
- ❑ Canker sores
- ❑ Celiac's disease
- ❑ Constipation
- ❑ Depression
- ❑ Diarrhea or loose stools
- ❑ Difficulty concentrating
- ❑ Emotional upset
- ❑ Eczema
- ❑ Fatigue or sudden drops of energy after meals
- ❑ Gas or bloating
- ❑ Heartburn or indigestion
- ❑ Hives
- ❑ Irritable bowel syndrome (IBS)
- ❑ Irritability
- ❑ Itching – skin or rectal

- ❑ Migraine headaches
- ❑ Nausea
- ❑ Nocturnal enuresis
- ❑ Red rash around mouth, reddening or swelling of skin
- ❑ Rhinitis
- ❑ Runny nose
- ❑ Stiffness of joints
- ❑ Stomach ache
- ❑ Swelling of lips and face
- ❑ Swelling of the joints
- ❑ Vomiting
- ❑ Wheezing

Miscellaneous: Indicate any additional information about your symptoms of allergy:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____