Name: ____ Date: ______________

How were you referred?

Physician ____

Other ____

Self Referral

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

____

____

When 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:______________

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? ___________

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/Townhouse

Do you live: In the city In the suburbs Rural areas

Do you have a basement? Yes No

Is your home built on a slab? Yes No

Type of heating system: Steam (radiator) Electric Hot water baseboard Gas/Oil Furnace

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

Number 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 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

Glaucoma | Diarrhea | Anxiety | Back problems
Emphysema | Cataracts | Loss of hearing | PMS
Endometriosis | Infertility | Menopause

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

Do you smoke now? Yes No How much? _____________ Number of Years _____

Family History

M-Mother F-Father G-Grandparents S-Self O-Other

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

____

____

____

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 allery:

____

On average what do your meals consist of: (including fluids)

Breakfast

Lunch

Dinner

Snacks

Please list favourite foods/commonly consumed foods: