



Patient Name: _____ D.O.B. ____/____/____

Age: _____ Name of Family Doctor: _____

**** PLEASE ANSWER ALL QUESTIONS AS COMPLETELY AS POSSIBLE ****

1. What problem(s) bring you to the allergist? _____

2. DO YOU HAVE:

	YES	NO		YES	NO		YES	NO
<u>EYES</u>			<u>EARS</u>			<u>CHEST</u>		
Itching	[]	[]	Itching	[]	[]	Cough	[]	[]
Watering	[]	[]	Fullness	[]	[]	Sputum	[]	[]
Swelling	[]	[]				Wheeze w/colds	[]	[]
Redness	[]	[]				w/exercise	[]	[]
Discharge	[]	[]				Shortness of breath		
			<u>HEADACHES</u>	<u>YES</u>	<u>NO</u>	At rest	[]	[]
				[]	[]	w/activity	[]	[]
							<u>YES</u>	<u>NO</u>
<u>NOSE</u>	<u>YES</u>	<u>NO</u>	<u>THROAT</u>	<u>YES</u>	<u>NO</u>	<u>SKIN</u>		
Sneezing	[]	[]	Itching of Palate	[]	[]	Eczema	[]	[]
Itching	[]	[]	Post-Nasal Drip	[]	[]	Hives	[]	[]
Watery Discharge	[]	[]	Snoring	[]	[]			
Congestion	[]	[]	Do you (patient) stop breathing at night?	[]	[]	<u>GASTROINTESTINAL</u>	<u>YES</u>	<u>NO</u>
Mouth Breathing	[]	[]	Do you have excessive Daytime sleepiness?	[]	[]	Heartburn	[]	[]
Loss of Smell	[]	[]				Cough after Meals	[]	[]
						Throat Clearing	[]	[]
						Diarrhea	[]	[]

3. SYMPTOMS

How long have they been present? _____

Are symptoms getting better or worse? _____

Do symptoms interfere with work? _____ Sleep? _____ Activity? _____

Is there a seasonal pattern to your symptoms? _____

If yes, what season(s) are worse? _____



4. ENVIRONMENT

Location of home: City _____ Suburb _____ Country _____

Type of home: YES NO YES NO

Single Dwelling [] [] Ranch [] []

2 Story [] []

Basement [] [] Crawlspace [] []

Apartment [] [] Floor _____

Modular Home [] []

Heating System _____ Air Conditioning [] []

Air Purifier [] [] Wood Stove [] []

Moisture Problems [] []

Age of home? _____ How long have you lived in the home? _____

Bedroom: Location _____ Pets in bedroom [] []

Pillow Type _____ Mattress type _____

Carpeting [] [] Age of Carpeting _____

Pets: Dog _____ Cat _____ Bird(s) _____ Other _____

Smokers in Home? [] [] Do you smoke? [] []

Occupation: _____

Hobbies: _____

5. ARE YOUR SYMPTOMS AFFECTED BY:

Dust - YES NO
[] []

Animals - Cat [] []

Dog [] []

Other _____

Mold: Old Leaves _____ Lawn Mowing _____ Summer Home _____

Damp Basement _____ Beer/Wine _____

Pollen: Spring / Early Summer _____ Late Summer / Fall _____



5. ARE YOUR SYMPTOMS AFFECTED BY:

Physical Factors: Heat _____ Cold _____ Air Conditioning _____
Exercise _____ Infections _____ Cigarette Smoke _____
Fumes _____ Dampness _____ Weather Changes _____

6. DO YOU HAVE ANY FOOD ALLERGIES / SENSITIVITIES? YES [] NO []
Which foods? _____

7. DO YOU HAVE ANY DRUG ALLERGIES? YES [] NO []
What drugs? _____

8. INSECT ALLERGIES? YES [] NO []

9. HABITS YES [] NO []
Do you smoke [] []
Do you drink [] []

Medications: Thyroid [] []
Birth Control Pills [] []
Beta Blockers _____
Non-Prescription nasal sprays _____
Other _____

THANK YOU FOR TAKING THE TIME TO ANSWER THESE QUESTIONS!