Patient Name _____ **Date of Birth** _____

WHAT IS YOUR ALLERGY PROBLEM? □Hay fever □Sinus infection □Asthma □Hives □Eczema □Food allergy □Insect allergy □Medication allergy □Other: _____

Have you ever seen an allergist? □No □Yes. If yes, when? _____ Testing done? □No □Yes.
If tested, what tests were positive? _____

HAY FEVER/UPPER RESPIRATORY/SINUS PROBLEMS:

NOSE: □Nasal congestion □Runny nose □Sneezing □Sniffling □Loss of smell/taste □Nasal itching □Snoring □Mouth breathing □Post nasal drainage

THROAT: □Sore throat □Itching of throat □Post nasal drainage □Tickling in throat

EYES: □Redness □Itching □Watering □Swelling □Puffiness

EARS: □Popping □Fullness □Itching □Infection □Pain

SINUS: □Infection? □How frequent? _____ times per year.
Seasonal? □No □Yes If yes, when? J F M A M J J A S O N D

When did your symptoms begin? □Childhood (age:) □Adult onset (age:)

During which times of the year do your symptoms mostly occur:
□Persistent (year round) □Random (no pattern) □Seasonal: □Winter □Spring □Summer □Fall

Which months of the year are the symptoms present? J F M A M J J A S O N D

What time of day do your symptoms occur: □Morning □Afternoon □Evening □After going to bed

What do you think may be exacerbating you symptoms?

OUTDOORS	**INDOORS**	**OTHER**
□ Mowing lawn	□ Dusting/vacuuming	□ Perfume
□ Walking/running	□ Bedroom environment	□ Smoke
□ Exercising	□ Bathroom environment	□ Hair/Chemical sprays
□ During/after rain	□ Basement/Attic	□ Smog/Auto exhaust
□ Changes in humidity/weather	□ Cats/Dogs/Other animals	□ Work exposure to: _____
□ Other: _____	□ Other: _____	□ Other: _____

How have your symptoms been treated in the past?
□Antihistamines. Names? _____
□Helped □Did not help.
Any adverse effects? □No □Yes. If yes, what? _____
□Nasal sprays □Non-prescription. Names? _____
□Prescription. Names? _____
□Helped □Did not help.
Any adverse effects? □No □Yes. If yes, what? _____

Have you missed any school or work days because of your nasal problems in the past 2 years?

□No □Yes. If yes, how much? Explain. _____

ASTHMA/BRONCHITIS

Have you had a diagnosis of asthma? □No □Yes.

If yes, when did your symptoms begin? □Childhood (age:) □Adult onset (age:)

What symptoms have you experienced? □Chest congestion □Chest tightness □Shortness of breath □Coughing □Wheezing

During which times of the year do your symptoms mostly occur:

□Persistent (year round) □Random (no pattern) □Seasonal: □Winter □Spring □Summer □Fall

Which months of the year are the symptoms present? J F M A M J J A S O N D

What time of day do your symptoms occur: □Morning □Afternoon □Evening □After going to bed

What do you think may be exacerbating you symptoms?

OUTDOORS	**INDOORS**	**OTHER**
□ Mowing lawn	□ Dusting/vacuuming	□ Perfume/Smoke
□ Walking/running	□ Bedroom environment	□ Hair/Chemical sprays
□ During/after rain	□ Basement/Attic	□ Smog/Auto exhaust
□ Changes in humidity/weather	□ Cats/Dogs/Other animals	□ Work exposure to: _____
□ Other: _____	□ Other: _____	□ Other: _____

Does emotional stress seem to aggravate your asthma? □No □Yes. If yes, explain: _____

Have you been hospitalized for your asthma? □No □Yes.

If yes, how many times? _____. When was the last time? _____

Have you been to urgent care and/or emergency department for your asthma?

□No □Yes. If yes, how many times in the past 3 years? _____

Have you been on medications for treatment of asthma? □No □Yes. If yes, which ones from the following:

Oral	**Before**	**Current**	**Rescue Inhaler**	**Before**	**Current**	**Daily Inhaler**	**Before**	**Current**
Singulair	□	□	Albuterol	□	□	Advair	□	□
Prednisone	□	□	ProAir	□	□	Dulera	□	□
Theophylline	□	□	Ventolin	□	□	Symbicort	□	□
			Proventil	□	□	Asmanax	□	□
			Levoalbuterol	□	□	Flovent	□	□
			Xopenex	□	□	Pulmicort	□	□
Other:						Qvar	□	□

Do you have a peak flow meter? □No □Yes. If yes, what is the range of your readings? _____

Have you missed any school or work days because of your breathing problems in the past 2 years?

□No □Yes. If yes, how much? Explain. _____

ALLERGY IMMUNOTHERAPY:

Have you ever been on allergy shots? □No □Yes. If yes, dates: _____. Did they help? □No □Yes.

Any severe reaction to allergy shots? □No □Yes. If yes, describe: _____

OTHER ALLERGIC CONDITIONS:

Do you have any known drug allergies? □No □Yes. If yes, explain:

Do you have any known food allergies? □No □Yes. If yes, explain:

Do you have any contact allergies? □No □Yes. If yes, explain:

Do you have any stinging insect allergies? □No □Yes. If yes, explain:

Have you ever had any hives? □No □Yes. If yes, explain:

Have you ever had eczema? □No □Yes. If yes, explain:

ENVIRONMENTAL SURVEY:

Where do you live? □Apartment □House □Townhouse

How old is it? _____ years old. How long have you lived there? _____ months / years

Is it air-conditioned? □No □Yes. If yes, □Central air-conditioning □Window units.

What type of heating do you have? □Gas □Heat pump □Radiator □Wood stove □Other: _____

Do you have a humidifier? □No □Yes. If yes, is it: □Central □Separate units

Does the house have a basement? □No □Yes. If yes, is it: □Finished □Unfinished □Dry □Damp □Flood

Living room floors: □Hardwood □Carpet

Family room floors: □Hardwood □Carpet

Bedroom floors: □Hardwood □Carpet

Do you have any encasings for: □Pillows □Box spring □Mattress

PETS:

Do you have pets? □No □Yes.

If yes, □ Cat □Dog □Bird □Gerbil □Hamster □Other: _____

How many do you have? _____

Are the pet(s): □Mostly outdoors □Mostly indoors □Not allowed in bedroom □Allowed in bedroom □Allowed to sleep on bed

PERSONAL INFROMATION

Marital status: □Single □Married

Current occupation: _____

Smoking history: □Never □Before □Now. How much? _____ packs per day. For how long? _____

Does anyone else in the house smoke? □No □Yes

Drug use? □No □Yes. If yes, which ones and how much? _____

Alcohol use? □No □Yes. If yes, how much? _____

Are you under any significant personal or work related stress? _____

Do you exercise regularly? _____

FAMILY HISTORY OF ALLERGY:

Is there a family history of allergy? □No □Yes. If yes, who has it: _____

What do they have? □Hay fever □Sinus problems □Asthma □Eczema □Food allergy □Drug allergy □Insect allergy □Other: _____

WHAT OTHER MEDICAL PROBLEMS DO YOU HAVE?

_____
_____
_____
_____
_____
_____
_____
_____
_____

PAST SURGERIES:

_____
_____
_____
_____
_____

CURRENT MEDICATIONS:
