

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_ DATE: \_\_\_\_\_

1. I was referred to see the allergist by \_\_\_\_\_. My primary care physician is \_\_\_\_\_.

2. I am/was having the following problem: \_\_\_\_\_

\_\_\_\_\_

3. My emergency contact is \_\_\_\_\_. They can be phoned at \_\_\_\_\_.

4. If a child, Mom's name/number is \_\_\_\_\_ and Dad name/ number \_\_\_\_\_.

5. My daytime phone number best to be reached at is \_\_\_\_\_.

6. LIST **SURGERIES OR HOSPITALIZATIONS**: \_\_\_\_\_

\_\_\_\_\_

7. LIST **CURRENT MEDICATIONS AND DOSAGES**: \_\_\_\_\_

\_\_\_\_\_

8. LIST ANY **MEDICATION ALLERGIES AND WHAT REACTION YOU HAD**: \_\_\_\_\_

\_\_\_\_\_

9. Does mother, father, sibling, or child have the following: **Circle all family members who have the condition.**

Hay fever or Allergy	Yes or No	Mother	Father	Sibling	Child
Sinus Problems	Yes or No	Mother	Father	Sibling	Child
Asthma	Yes or No	Mother	Father	Sibling	Child
Hives	Yes or No	Mother	Father	Sibling	Child
Eczema	Yes or No	Mother	Father	Sibling	Child
Food Allergy	Yes or No	Mother	Father	Sibling	Child

10. Does the patient **currently smoke**? Yes or No If so, How much?  
 Has the patient **ever smoked**? Yes or No If so, when did the patient quit?  
 Does the patient drink **alcohol**? Yes or No If so, how often?

11. Does the **patient work**? Yes or No What type of work does the patient do? \_\_\_\_\_  
 How long has the patient done this type of work? \_\_\_\_\_ Are symptoms worse at work? Yes or No

12. If the patient is a **child**, Do they attend **school daycare home sitter** If so, how many other children are in class? \_\_\_\_\_

13. I have noticed the following **triggers** make the patient's symptoms worse: Circle all that apply

- GRASS WEED RAGWEED TREES DUST RAIN LEAVES/MULCH CAT DOG HORSE HAY  
 MOLD TOBACCO SMOKE WEATHER CHANGES RESPIRATORY INFECTIONS COLOGNES/STRONG ODORS  
 EMOTIONS UNKNOWN FOODS (PLEASE LIST) \_\_\_\_\_

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14. **Environmental History:** PLEASE ANSWER ALL QUESTIONS BELOW, PAYING SPECIAL ATTENTION TO THE BOLD AREAS.

Do you live in a **house**, **apartment**, or **mobile home**? It is made of **brick**, **frame/siding**, **stone**, **block**.

Your home is **how old**? \_\_\_\_\_ and you have lived there **how long**? \_\_\_\_\_

Does your home have a **basement** or a **crawl space** or **cement foundation**? Is it **damp** or **dry**?

Is your house located in the **city**, **suburbs**, or **rural area**?

Do you use **gas**, **electric**, **heat pump**, or **wood** for heat? Do you use **central air** or **window unit** for air conditioning?

Do you use an **air cleaner**, **humidifier**, **dehumidifier**, or **none**? Is it used throughout the **whole home** or just in one **room**?

Does anyone **smoke** in the **home**? Yes or No Does anyone **smoke** in the **car**? Yes or No **How many smokers?** 1 2 3 4+

Do you have **stuffed toys in the bedroom**? Yes or No If so, approximately how many? \_\_\_\_\_

Do you have **indoor house plants**? Yes or No If so, **how many**? \_\_\_\_\_ How many are any in the **bedroom**? \_\_\_\_\_

Do you sleep with **feather** or **synthetic** pillows? **How old** are the pillows? \_\_\_\_\_ Are **allergen proof coverings** used? Yes or No

Do you sleep on a regular **mattress/box springs**, **foam mattress**, or **couch/futon**? How old is the **mattress**? \_\_\_\_\_

The bedroom floor is **carpet**, **tile**, **wood**, or **vinyl**?

Do you have indoor **cats** or **dogs**? Do they go in your bedroom? **Yes** or **No** Do they **sleep** in your **bed**? Yes or No

Do you have outdoor **cats** or **dogs** or other animals (please list)?

15. **Circle all that apply** to your current symptoms or your past chronic symptoms. Read **each category** next to the arrow.

Do you have:

- Skin condition like Eczema, Seborrhea, contact dermatitis, hives, swelling, rash
- Sinus pressure, fullness in sinus region, teeth ache Last xray of sinuses was? \_\_\_\_\_ Never
- Eyes that itch, burn, dryness, red eyes, water, swell, dark circles, glaucoma, contacts
- Ears that have fluid, pop, fullness, itching, ringing, ear aches, ear tubes, ear infections
- Nose that is stuffy, sniffing, itching, loss of smell or taste, nose bleeds, runny nose/what color ?
- Post nasal drip, tonsil or throat infections, bad breath, throat clearing, itching throat, hoarseness
- Cough, shortness of breath, wheezing in chest, waking in the night, chest tightness Last chest xray was? \_\_\_\_\_  
How often do you have chest symptoms? Daily, \_\_\_\_\_ x per week, \_\_\_\_\_ x per month, \_\_\_\_\_ x per year
- High blood pressure, heart murmur, heart skips, coronary artery disease, heart palpitations
- Arthritis, fibromyalgia, lupus, other auto-immune disease
- Reflux/heartburn, suspected food reactions, hiatal hernia, ulcer
- Prostate problems, kidney disease, urinary retention
- Headaches, Migraines, seizures
- Thyroid problems, Diabetes