

Physician Referral: Yes \_\_\_ No \_\_\_ Physician's Name \_\_\_\_\_

Describe symptoms/problems being seen for today: \_\_\_\_\_

Duration of symptoms: Years \_\_\_\_\_ Months \_\_\_\_\_

When do symptoms become worse? Spring \_\_\_ Summer \_\_\_ Fall \_\_\_ Winter \_\_\_ Year Round \_\_\_

***Do you experience the following symptoms? (check all that apply)***

Significant sneezing \_\_\_ If yes, any certain time of day? \_\_\_\_\_

Nasal congestion: \_\_\_ Nasal drainage: clear \_\_\_ discolored \_\_\_

Drainage down back of throat: \_\_\_ Frequent throat clearing: \_\_\_

Itchy nose: \_\_\_ Sense of smell: good \_\_\_ poor \_\_\_

Facial pressure: \_\_\_ If so, location: \_\_\_\_\_

Eyes: itch \_\_\_ burn \_\_\_ sting \_\_\_ dry \_\_\_ pain \_\_\_ decreased vision \_\_\_

Cough: dry \_\_\_ loose/moist \_\_\_

Cough: daytime (while up) \_\_\_ nighttime (while laying down and/or asleep) \_\_\_

Sputum production: clear: \_\_\_ discolored \_\_\_ none \_\_\_

Triggers for cough: vigorous physical activity \_\_\_ laughter \_\_\_ meals \_\_\_

Wheezing (high pitched sound made when breathing): while breathing in \_\_\_ breathing out \_\_\_

Chest tightness: \_\_\_

Itchy skin: \_\_\_

Skin rash (if so, describe location on body): \_\_\_\_\_

Heartburn/reflux: \_\_\_ Hoarseness: \_\_\_

Problems swallowing: liquids \_\_\_ solids \_\_\_ both \_\_\_

For children: frequent vomiting \_\_\_ nausea \_\_\_ abdominal pain \_\_\_ refusal to eat \_\_\_ weight loss \_\_\_

Snoring: mild \_\_\_ moderate/severe \_\_\_

Headaches: constant \_\_\_ throbbing \_\_\_ accompanying nausea/vomiting \_\_\_

Daily \_\_\_ If not daily, number of days per month \_\_\_\_\_

Location of pain \_\_\_\_\_

***Exposure to which of the items below can make symptoms worse?***

Weather/barometric pressure changes \_\_\_\_\_ Smoke/air fresheners/perfumes, etc. \_\_\_\_\_

Dust (such as produced with vacuuming or sweeping) \_\_\_\_\_ Moldy environments \_\_\_\_\_

Foods \_\_\_\_\_ Grass \_\_\_\_\_ Furred animals (specific ones) \_\_\_\_\_

Prior Allergy Consultation: Have you seen an allergist in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please indicate the year: \_\_\_\_\_ The physician's name: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_

Were you ever placed on allergy injections? Yes \_\_\_\_\_ No \_\_\_\_\_

**Medications:**

List ALLERGY MEDICATIONS taken in the last month (include over-the-counter or prescription tablets, liquids, inhalers, or creams). Indicate frequency of use and length of time on each medication:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

List OTHER MEDICATIONS taken routinely or intermittently for medical reasons (asprin, blood pressure drugs, etc.).

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

If child, immunizations up to date: Yes \_\_\_\_\_ No \_\_\_\_\_

List the approximate number of times antibiotics were prescribed in the past 6 months (specific names if known).

\_\_\_\_\_  
\_\_\_\_\_

List Medication Allergies or Side Effects to Medications

<i>Drug/Medication</i>	<i>Describe reaction</i>
_____	_____
_____	_____
_____	_____
_____	_____

List Hospitalizations (associated with condition(s) being seen for including tubes in ears, tonsillectomy/adenoidectomy, etc.)

<i>Year</i>	<i>Procedure done/Problem</i>
_____	_____
_____	_____
_____	_____
_____	_____

**Immediate Family History:**

Please indicate which of your family members have had allergies with the appropriate letters:

A = Asthma, NA=Nasal allergies, E = Eczema

Father \_\_\_\_\_ Mother \_\_\_\_\_ Brother \_\_\_\_\_  
Sister \_\_\_\_\_ Son \_\_\_\_\_ Daughter \_\_\_\_\_

**Environmental History:**

(for children living in dual homesteads, please complete environmental history for both. Use back of page if necessary)

*Home:*

Urban \_\_\_\_\_ Rural \_\_\_\_\_ Apartment \_\_\_\_\_ Mobile Home \_\_\_\_\_

How long have you lived at your present location? \_\_\_\_\_

How old is the home? \_\_\_\_\_

Family members (ages of children if in home)

Basement? None \_\_\_\_\_ Dry \_\_\_\_\_ Damp \_\_\_\_\_

Heating? Central \_\_\_\_\_ Heat Pump \_\_\_\_\_ Gas \_\_\_\_\_

Air Conditioning? Central \_\_\_\_\_ Window \_\_\_\_\_ None \_\_\_\_\_

Does anyone smoke in the home? Yes \_\_\_\_\_ No \_\_\_\_\_

Animals (inside)? Yes \_\_\_\_\_ No \_\_\_\_\_ Cat \_\_\_\_\_ Dog \_\_\_\_\_ Rabbit \_\_\_\_\_ Hamster \_\_\_\_\_

Other inside animals: \_\_\_\_\_

Animals (outside)? Yes \_\_\_\_\_ No \_\_\_\_\_ Cat \_\_\_\_\_ Dog \_\_\_\_\_ Rabbit \_\_\_\_\_

Other outside animals: \_\_\_\_\_

Have roaches been seen in the home? Yes \_\_\_\_\_ No \_\_\_\_\_

Family member (including parents) in full or part time day care environment? Yes \_\_\_\_\_ No \_\_\_\_\_

*Bedroom:*

Floor: Carpet \_\_\_\_\_ Tile \_\_\_\_\_ Wood \_\_\_\_\_ Other \_\_\_\_\_

Do you have zippered mattress encasings? Yes \_\_\_\_\_ No \_\_\_\_\_

Pillows: Synthetic \_\_\_\_\_ Feather \_\_\_\_\_ Pillow encasements: Yes \_\_\_\_\_ No \_\_\_\_\_

Stuffed animals in bedroom? Many \_\_\_\_\_ Few \_\_\_\_\_ None \_\_\_\_\_

**Occupation/Social History:**

Type of work you are doing currently:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you smoke tobacco products? Yes \_\_\_ No \_\_\_ If so, \_\_\_ packs per day. Number of years \_\_\_

Past tobacco use: Yes \_\_\_ No \_\_\_ Quit in year \_\_\_ Packs per day \_\_\_ Number of Years \_\_\_

Alcohol use: Yes \_\_\_ No \_\_\_ Socially \_\_\_ Never \_\_\_

**Dietary History:**

Are there foods you cannot eat because of allergic reactions? Yes \_\_\_ No \_\_\_ If yes, please list food and reaction.

*Food*

*Reaction*

_____	_____
_____	_____
_____	_____
_____	_____

This information is part your medical record, and is a legal document. It will only be released upon your request and signature of a Medical Record Release of Information.