Patient's Name	Date of Birth
Date of Appointment	Referring Physician

1. Instructions: *Please answer the questions as they relate to the person being evaluated. Bring this form with you to your first appointment.*

Briefly describe the reason for your allergy visit and what you hope to accomplish.

2. Problems: *Have you ever had the following conditions?*

Yes	No	**(Check all items that apply)**	Age of Onset				Comments
		Asthma (wheezing)		Mild	Mod.	Severe	
		Any Other Breathing Problems					
		Sinus Trouble					
		Hay Fever (Runny, stuffy, itchy nose, sneezing)					
		Hives or Swelling					
		Eczema or Other Rashes					
		Frequent infections					
		Food Reactions					
		Drug Reactions					
		Insect Reactions					

3. Symptoms: *Have you ever had any of the following? If not, leave blank.*

	How many days In the last month	**Mild**	**Mod.**	**Severe**	**Circle the Months Most Severe**
Runny or stuffy nose					**J F M A M J J A S O N D**
Itchy nose					**J F M A M J J A S O N D**
Sneezing					**J F M A M J J A S O N D**
Wheezing					**J F M A M J J A S O N D**
Coughing					**J F M A M J J A S O N D**
Wheezing or coughing with exercise					**J F M A M J J A S O N D**
Skin Problems					**J F M A M J J A S O N D**

4. Precipitating Factors / Triggers: *For each item below, check the appropriate square to indicate whether you (or your child's) condition is affected by the following triggers.*

Condition Made Worse	Condition Improved	No Change	
☐	☐	☐	Cutting or playing in grass, raking leaves , other outdoor exposure.
☐	☐	☐	High winds, riding in auto.
☐	☐	☐	Moldy / mildewed areas or items
☐	☐	☐	Sweeping, dusting or vacuuming
☐	☐	☐	Smog, smoking or smoke exposure
☐	☐	☐	Air conditioning or heating
☐	☐	☐	Cleaning agents, detergents, ammonia, Bleach, soap, conditioner, shaving cream, Toothpaste etc. Specify:_____
☐	☐	☐	Paint, lacquer, glue, mothballs, motor fumes, chemicals, fertilizers, insect spray, cooking Odors, etc. Specify:_____

Condition Made Worse	Condition Improved	No Change	
☐	☐	☐	Other strong odors. Specify; _____
			Medications:
☐	☐	☐	Antihistamines or cold preparations
☐	☐	☐	Asthma medication
☐	☐	☐	Nose drops or spray.
☐	☐	☐	Aspirin
☐	☐	☐	Other_____
☐	☐	☐	Exposure to animals Specify;_____
☐	☐	☐	Colds or viruses
☐	☐	☐	Physical exertion or exercise
☐	☐	☐	Cold weather
☐	☐	☐	Other factors_____

5. Residence: List all places lived by city and state, approximate dates, effects on your problem.

City & State	*Dates*	*Effect on Symptoms (better, worse, no change)*
1.		
2.		
3.		
4.		
5.		

6. Previous Allergy Evaluation and Therapy

Have you ever had allergy skin tests? Yes____ No____ if yes, date Physician's Name

Results of these tests: (If possible, please provide us with a copy)

Have you ever had allergy injections? Yes No If yes, dates

7. Medications (Bring all medications with you to your appointment.)

Please list **all** medication that you are currently taking, name, dosage and number of times a day:
Please list all medications you have taken for allergies in the past:
/
Are You Allergic to Any Medications? Please list:

8. Other Medical Problems: Have you ever had any of the following. Answer all items.

Yes	No		Yes	No		Yes	No	
		Frequent Headaches			Pneumonia, number past year_____			Liver trouble
		Frequent Nosebleeds			Coughed up blood			Frequent Diarrhea
		Nasal Polyps			Tuberculosis			Bedwetting
		Operations on Sinuses			Chest X-Ray			Poison Ivy or Oak
		Sinus X-Rays			Heart trouble			Latex
		Ear Infections, # in past year _____			High blood pressure			Other:
		Hearing Problems			Frequent heartburn			
		Glaucoma			Diabetes			
		Tonsils / Adenoids (year removed____)			Kidney or bladder trouble			

9. Immunizations: (List dates and reactions, if any)

Polio	Measles
DPT	Rubella (German Measles)
Tetanus Booster	Influenza
Other (Pneumonia vaccine, etc.)	

10. Hospitalizations / Surgeries

List most recent first	Reason	Date
1.		
2.		
3.		
4.		
5.		
6.		

11. Family History

Do any members of your family have a history of any of the following?

	Yes	No	If yes, list all relatives. (parents, brothers, sisters, children, etc.)
Asthma			
Hay Fever			
Eczema			
Hives			
Swelling			
Frequent Pneumonia			
Headaches			
Other Allergies			
Is there a family history of any other illnesses?			
Emphysema or other Lung Disease			
Cystic Fibrosis			
Tuberculosis			
Thyroid Disease			
Glaucoma			
Diabetes			
Other			

12. Tobacco Use / Weight

Have you ever smoked? Yes ☐ No ☐ If yes, how many years?
Do you presently smoke? Yes ☐ No ☐ When did you stop?
Average cigarettes per day at highest point? Do you want to stop? Yes ☐ No ☐
Which other members of your household now smoke?
Do you use other forms of tobacco (chew, snuff, etc.)?
Weight now: Weight one year ago: Maximum weight: When?

13. Environmental Survey

Where do you live? (city or rural)	Age of house:
Type of house (mobile, single family, apt.)	Number of indoor plants?
Are any rooms damp or musty?	Raised foundation or slab?
Do you have : an air cleaner?	An air dehumidifier?
Type of heating:	Type of air conditioning:
Type of flooring in the following rooms (carpet, tile, hardwood, etc.):	
Bedrooms: Living room:	Family room:
How old is your pillow? Is your pillow: Feather ☐ Dacron ☐ Foam rubber ☐	Encased in plastic ☐ Other ☐
How old is your mattress? Type of mattress?	Encased?
Do you have pets? List number and kind, and how long you have had them?	
Do your pet spend time indoors?	
What type of work do you do?	
Are you exposed to anything at work that might aggravate your condition?	Which things?
Have you missed any time from work or school because of your allergies?	How much time?
Have you missed any time from work or school because of your asthma?	How much time?
Do you have any other exposures from hobbies, recreational activities, etc?	

Do you have further information you feel is important for us to kn*ow?*