NAME_____M____F____ AGE_____ DATE _____

PRIMARY PHYSICIAN _____ REFERRING PHYSICIAN _____

SYMPTOMS (DESCRIBE): _____

_____

Circle all that apply:

RUNNY NOSE (color) _____
STUFFY NOSE
SNEEZING, ITCHY NOSE,
ITCHY EYES, WATERY EYES
POST NASAL DRIP
NOSE BLEEDS
DIZZINESS, VERTIGO
DECREASED SENSE OF SMELL
SINUS PAIN, HEADACHE
RECURRENT SINUS INFECTIONS
EARACHE — SORE THROAT

HOARSENESS
COUGHING
CHEST PAINS
WHEEZING (at night - day - with exercise)
SHORTNESS OF BREATH (night - day)
COUGH (day - night - with exercise)
RECURRENT PNEUMONIA _____/yr
RECURRENT BRONCHITIS _____/yr
OTHER INFECTIONS:_____

OTHER SYMPTOMS
_____

HIVES: _____

CAUSE OF HIVES? _____

ECZEMA _____

OTHER RASH _____

WORST SEASON: _____

BEST SEASON: _____

ARE SYMPTOMS YEAR ROUND? _____

FOR HOW LONG HAVE YOU HAD THIS PROBLEM? _____ IS IT GETTING BETTER OR WORSE?_____

SEVERITY: (1 NOT SEVERE —— 10 VERY SEVERE) _____
WHAT MAKES YOUR SYMPTOMS WORSE? _____
WHAT MAKES YOUR SYMPTOMS BETTER? _____
IS YOUR CONDITION WORSE?: (CIRCLE) AT WORK — AT HOME — INDOORS — OUTDOORS - IN TOWN - OUT OF TOWN
IS YOUR CONDITION WORSE? STANDING? - LAYING DOWN? - AFTER EXERCISE? - AFTER A MEAL? - AFTER A SHOWER?

LIST ALL CURRENT MEDICATIONS: PRESCRIPTION AND/OR OVER THE COUNTER (INCLUDE EYE DROPS, VITAMINS)

MEDICINE NAME	DOSE	TIMING	PRESCRIBING DR.	TAKEN SINCE WHEN?

PREVIOUS ALLERGY TREATMENT: OVER THE COUNTER MEDICATIONS: _____
PRESCRIPTION MEDICATIONS: (PLEASE INCLUDE ORAL MEDS, INHALERS AND NOSE SPRAYS)

_____
_____
_____
_____
WHICH MEDICINES HAVE HELPED YOU THE MOST? _____

HAVE YOU EVER HAD ALLERGY TESTING? (CIRCLE) YES NO WHEN? _____ WHERE? _____ RESULTS? _____
HAVE YOU EVER TAKEN ALLERGY INJECTIONS? YES NO – FOR HOW LONG? _____ DID SHOTS HELP YOU?_____
HAVE YOU HAD REACTIONS TO ALLERGY SHOTS BEFORE? _____ WHAT KIND OF REACTIONS: _____

FAMILY HISTORY (NOT YOU): (CIRCLE) ALLERGIES -- ASTHMA -- SINUS -- HIVES -- ECZEMA - ARTHRITIS -- DIABETES - HEADACHES TB — FREQUENT PNEUMONIA — IMMUNE PROBLEMS — BRONCHITIS — EMPHYSEMA — DRUG ALLERGIES — CYSTIC FIBROSIS . OTHER: _____

MOTHER'S AGE: _____ CONDITIONS: _____FATHER'S AGE: ____ CONDITIONS: _____
SIBLINGS: #1: M/F AGE: ____ CONDITIONS: _____#2: M/F AGE: _____ CONDITIONS: _____
OTHERS:_____

HOSPITALIZATIONS: PLEASE INCLUDE DATES AND REASON: _____

SURGERY (INPATIENT OR OUTPATIENT): INCLUDE DATES AND TYPE OF SURGERY:_____

HAVE YOU EVER BEEN DIAGNOSED WITH? (CIRCLE ALL APPLICABLE)
GLAUCOMA — ASTHMA — HAY FEVER — SINUS PROBLEMS — NASAL POLYPS — RECURRENT INFECTIONS — CHRONIC BRONCHITIS — EMPHYSEMA — PNEUMONIA — TB — ECZEMA — HIVES — WEAK IMMUNE SYSTEM — LUPUS — RHEUMATOID ARTHRITIS — HEART CONDITIONS — HIGH BLOOD PRESSURE — STOMACH ULCERS

LIST ALL OTHER MEDICAL CONDITIONS FOR WHICH YOU ARE BEING TREATED OR WERE TREATED IN THE PAST:

DO YOU HAVE PROBLEMS WITH OR A HISTORY OF: DO YOU HAVE ANY OF THE FOLLOWING (CIRCLE ALL THAT APPLY):
FREQUENT FEVER –SWEATS – CHILLS- WEIGHT LOSS (____LBS. IN _____MONTHS) WEIGHT GAIN (____LBS. IN ____MONTHS) - JOINT PAINS – ARTHRITIS – LUPUS – MUSCLE PAINS- IMMUNE PROBLEMS - FREQUENT HEADACHES –NOSEBLEEDS- THYROID DISEASE – DIABETES – OSTEOPENIA OR OSTEOPOROSIS - NASAL POLYPS - SINUS SURGERY – GLAUCOMA - CANCER – PNEUMONIA – TB – HEART CONDITIONS – CHEST PAINS - HIGH BLOOD PRESSURE – HEARTBURN – VOMITING- DIARRHEA – LIVER PROBLEMS – KIDNEY OR URINARY PROBLEMS – ABNORMAL BLEEDING – BRUISING -HIGH CHOLESTEROL – DEPRESSION - ANXIETY
OTHER SYMPTOMS: _____

ALLERGIC REACTIONS TO MEDICINES, FOODS AND INSECTS:

MEDICINE	TYPE OF REACTION	DATE OCCURRED
FOOD		
INSECT		

ENVIRONMENT : PLACE OF BIRTH: _____ LIST ALL PLACES YOU HAVE LIVED FOR MORE THAN ONE YEAR:

FOR HOW LONG HAVE YOU LIVED IN OUR AREA? _____ ARE YOUR SYMPTOMS WORSE IN THIS AREA? _____
AGE OF YOUR HOME _____ MAINLAND? — BEACHSIDE? HOW FAR IS YOUR HOME FROM THE OCEAN? _____
DO YOU SPRAY INDOORS FOR INSECTS? YES NO DO YOU HAVE PETS?____ WHAT KIND OF PETS? _____ INDOOR PETS OR STRICTLY OUTDOOR PETS? _____ARE YOU EXPOSED TO PETS FREQUENTLY ELSEWHERE? _____ WHAT PETS:_____

TYPE OF FLOORING: BEDROOM _____ LIVING/ FAMILY ROOM _____
EXPOSED WESTERN RED CEDAR WOOD?_____ ANY OTHER FUMES, DUSTS, ODORS: _____
DO YOU HAVE AND USE CEILING FANS Y N ANY SMOKERS INSIDE YOUR HOME? OR AT WORK?_ _____

DO YOU PRESENTLY SMOKE? Y N PACKS PER DAY? _____ LIKE TO QUIT? ___ (QUIT ____MONTHS ___YEARS AGO)
DO YOU DRINK ALCOHOL? Y N REGULARLY/ OCCASIONALLY; DO YOU USE ILLEGAL DRUGS Y N _____
WHAT IS OR WAS YOUR OCCUPATION? _____ CHEMICAL EXPOSURE? _____
OTHER: _____