

**PATIENT NAME:** \_\_\_\_\_  
**DATE OF BIRTH:** \_\_\_\_\_  
**OCCUPATION:** \_\_\_\_\_  
**CURRENT DATE:** \_\_\_\_\_

- 1 Name of person filling out this form and relation to the patient: \_\_\_\_\_
- 2 Who suggested you visit us? \_\_\_\_\_
- 3 Who is your primary physician? \_\_\_\_\_
- 4 Is there any other provider who should receive a copy of our report? \_\_\_\_\_
- 5 What is the reason you were referred to us today? (asthma, hay fever, food, bee, medication allergy, etc)  
 \_\_\_\_\_  
 \_\_\_\_\_
- 6 What specific problems or symptoms are you having?(sneezing, cough, etc.) \_\_\_\_\_  
 \_\_\_\_\_

**Please answer YES or NO if you have had any of the following within the past year or more:**

<p><b>NOSE</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>itch Y ___ N ___</p> <p>clear drainage Y ___ N ___</p> <p>discolored mucus Y ___ N ___</p> <p>sneezing Y ___ N ___</p> <p>post-nasal drip Y ___ N ___</p> <p>nose rubbing Y ___ N ___</p> <p>nosebleeds Y ___ N ___</p> <p>polyps Y ___ N ___</p> <p>poor sense of smell or taste Y ___ N ___</p> <p><b>SINUSES</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>fullness/pressure/pain Y ___ N ___</p> <p>recurrent sinusitis Y ___ N ___</p> <p>recurrent head colds Y ___ N ___</p> <p><b>CHEST</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>coughing Y ___ N ___</p> <p>wheezing Y ___ N ___</p> <p>tightness/pressure Y ___ N ___</p> <p>short of breath Y ___ N ___</p> <p>bronchitis Y ___ N ___</p> <p>pneumonia Y ___ N ___</p> <p>coughed up blood Y ___ N ___</p> <p>coughed up sputum Y ___ N ___</p> <p>trouble keeping up with peers when exercising Y ___ N ___</p> <p>wake up coughing/wheezing Y ___ N ___</p> <p>coughs with exercise Y ___ N ___</p> <p>ER visit for asthma attacks Y ___ N ___</p> <p>hospitalizations for asthma/pneumonia Y ___ N ___</p>	<p><b>EYES</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>tearing Y ___ N ___</p> <p>itching Y ___ N ___</p> <p>discharge Y ___ N ___</p> <p>redness Y ___ N ___</p> <p>dryness Y ___ N ___</p> <p>vision changes Y ___ N ___</p> <p>blurred vision Y ___ N ___</p> <p>glaucoma Y ___ N ___</p> <p>wear soft contacts? Y ___ N ___</p> <p><b>EARS</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>itch Y ___ N ___</p> <p>pop Y ___ N ___</p> <p>plugging Y ___ N ___</p> <p>infections Y ___ N ___</p> <p>poor hearing Y ___ N ___</p> <p>ringing Y ___ N ___</p> <p><b>Gastrointestinal</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>heartburn Y ___ N ___</p> <p>reflux Y ___ N ___</p> <p>vomiting Y ___ N ___</p> <p>diarrhea Y ___ N ___</p> <p>swallowing difficulties Y ___ N ___</p> <p>stomach pain Y ___ N ___</p> <p>food intolerance Y ___ N ___</p> <p>hepatitis Y ___ N ___</p> <p>bloating Y ___ N ___</p>	<p><b>THROAT &amp; MOUTH</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>itching Y ___ N ___</p> <p>recurrent sore throats Y ___ N ___</p> <p>hoarseness Y ___ N ___</p> <p>throat clearing Y ___ N ___</p> <p>bad breath Y ___ N ___</p> <p>canker sores Y ___ N ___</p> <p><b>SKIN</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>rash Y ___ N ___</p> <p>hives/welts Y ___ N ___</p> <p>swelling Y ___ N ___</p> <p>itching Y ___ N ___</p> <p>eczema Y ___ N ___</p> <p>dryness Y ___ N ___</p> <p><b>CONSTITUTIONAL</b></p> <p><i>no problems</i> Y ___ N ___</p> <p>headaches Y ___ N ___</p> <p>irritability Y ___ N ___</p> <p>aggressive behavior Y ___ N ___</p> <p>poor sleeping Y ___ N ___</p> <p>fatigue Y ___ N ___</p> <p>snoring Y ___ N ___</p> <p>cold/heat intolerance Y ___ N ___</p> <p>dizziness Y ___ N ___</p> <p>fever Y ___ N ___</p> <p>weight changes Y ___ N ___</p> <p>night sweats Y ___ N ___</p> <p>growth delay Y ___ N ___</p> <p>altered school/work performance Y ___ N ___</p> <p>loss of balance Y ___ N ___</p> <p>dizziness on change of positions Y ___ N ___</p>
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Which of the above are of greatest concern to you and impact most on your quality of life? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

7 Please provide us with some details of the history of your problem.  
 When did it begin? Was it preceded by some other type of allergic condition? Has there been a trend or variation of symptoms or severity over the years? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

8 Have you noticed a pattern with your symptoms? Is it worse in certain locations, months or seasons?  
 \_\_\_\_\_  
 \_\_\_\_\_

Are your symptoms affected by:

dust	Y	___	N	___	cut grass	Y	___	N	___	stress	Y	___	N	___
cats	Y	___	N	___	mold/mildew	Y	___	N	___	spring	Y	___	N	___
dogs	Y	___	N	___	wind	Y	___	N	___	summer	Y	___	N	___
other animals	Y	___	N	___	weather changes	Y	___	N	___	fall	Y	___	N	___
leaf raking	Y	___	N	___	fumes/chemical odors	Y	___	N	___	winter	Y	___	N	___
feathers	Y	___	N	___	poor air quality	Y	___	N	___	viruses	Y	___	N	___
soaps/detergents	Y	___	N	___	respiratory infections	Y	___	N	___	exercise	Y	___	N	___
exercise	Y	___	N	___	laughter	Y	___	N	___					
heat/cold	Y	___	N	___	newsprint	Y	___	N	___					

(See Question #15 for foods, bee stings, latex)

9 What has provided the most relief (avoidance, specific medicines, allergy shots...)?  
 \_\_\_\_\_  
 \_\_\_\_\_

10 What hasn't helped? \_\_\_\_\_  
 \_\_\_\_\_

11 If you have undergone prior allergy evaluation, please list physician, approximate date, and any known details regarding test results and treatment. \_\_\_\_\_  
 \_\_\_\_\_

12 Describe your smoking history:

never	Y	___	N	___	Average number of packs/day over the years	_____
former	Y	___	N	___	Numbers of years you have smoked	_____
current	Y	___	N	___	If applicable, how many years ago did you stop?	_____

13 Please list all current medications, both prescription and over the counter. Also list all herbal and/or nutritional products:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

14 Please list all known medication allergies and intolerances. Describe the nature of reaction or side effect for each drug and approximate date or age at which the problem surfaced. \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_

15 Please list all known or suspected allergies or intolerances to foods, food additives and colorants, stinging insect venom, and latex (natural rubber) products. Describe the nature of the reaction and approximate date or age at which the problem surfaced.

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

16 Have you had contact allergies to poison ivy, adhesives, metals, cosmetics, etc.? Describe:

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

17 If not yet covered above, have you had any of the following:

asthma	Y ___ N ___	recurrent sinusitis	Y ___ N ___	sinus surgery	Y ___ N ___
nasal allergies	Y ___ N ___	recurrent ear infections	Y ___ N ___	pneumonia	Y ___ N ___
eczema	Y ___ N ___	PE ear tubes	Y ___ N ___	recurrent bronchitis	Y ___ N ___
recurrent hives	Y ___ N ___	adenoidectomy	Y ___ N ___	meningitis	Y ___ N ___
recurrent swelling	Y ___ N ___	tonsillectomy	Y ___ N ___	abscesses	Y ___ N ___

18 Please describe your routine for regular exercise: \_\_\_\_\_

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

19 **Home Environment:** Age of home \_\_\_\_\_ rent \_\_\_\_\_ own \_\_\_\_\_

Number of indoor cats? \_\_\_\_\_ For how long? \_\_\_\_\_  
 Number of indoor dogs? \_\_\_\_\_ For how long? \_\_\_\_\_  
 Other furred pets in home? \_\_\_\_\_ For how long? \_\_\_\_\_  
 If cats or dogs were present only in past, how long has it been since such pets were in the home?  
 \_\_\_\_\_ What type of animal? \_\_\_\_\_

Number of occupants who ever smoke in the home? \_\_\_\_\_  
 Relationship of smoker(s) to patient? \_\_\_\_\_

Central AC? Y \_\_\_ N \_\_\_  
 If you have central AC do you routinely open windows seasonally, temperature permitting? Y \_\_\_ N \_\_\_

Your bedroom:  
 wall to wall carpet Y \_\_\_ N \_\_\_ hardwood or tile Y \_\_\_ N \_\_\_ area rugs Y \_\_\_ N \_\_\_  
 washable throw rugs Y \_\_\_ N \_\_\_ (not washable)  
 Are pillows covered in special allergen-proofed encasings? Y \_\_\_ N \_\_\_  
 Is top mattress similarly encased? Y \_\_\_ N \_\_\_ ( N/A if waterbed)  
 is box spring encased? Y \_\_\_ N \_\_\_ Is comforter encased? Y \_\_\_ N \_\_\_

Is patient in a daycare setting? Y \_\_\_ N \_\_\_ If so, how many other children in attendance? \_\_\_\_\_  
 Pets at daycare? \_\_\_\_\_ Smokers? Y \_\_\_ N \_\_\_

If you live much of the year in a college dorm or apartment, please comment on that setting with the above issues in mind: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are there any particular concerns regarding either the home or work setting not addressed above? (e.g., water damage, mold growth, leaky roof, poor ventilation, etc.) Please elaborate: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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20 Review of Systems (Have you had any of the following within the past year?)

<b>Heart</b>		<b>Musculoskeletal</b>		<b>Neuropsychiatric</b>	
<i>no problems</i>	Y ___ N ___	<i>no problems</i>	Y ___ N ___	<i>no problems</i>	Y ___ N ___
high blood pressure	Y ___ N ___	arthritis	Y ___ N ___	migraine	Y ___ N ___
irregular beats	Y ___ N ___	fibromyalgia	Y ___ N ___	seizures	Y ___ N ___
murmur	Y ___ N ___	osteoporosis	Y ___ N ___	unconscious spells	Y ___ N ___
heart attack	Y ___ N ___	backaches	Y ___ N ___	tingling/weakness	_____
surgery	Y ___ N ___	muscle spasms	Y ___ N ___	in hands/feet	Y ___ N ___
ankle swelling	Y ___ N ___	joint redness	Y ___ N ___	trembling of extremity	Y ___ N ___
angina/chest pain	Y ___ N ___	joint swelling	Y ___ N ___	difficulty concentrating	Y ___ N ___
<u>shortness of breath:</u>		joint heat	Y ___ N ___	impulsive behavior	Y ___ N ___
when walking	Y ___ N ___			chronic anxiety	Y ___ N ___
when lying down	Y ___ N ___	<b>Blood/Lymphatic</b>		memory difficulty	Y ___ N ___
when climbing		<i>no problems</i>	Y ___ N ___	stress	Y ___ N ___
1 flight of stairs	Y ___ N ___	anemia	Y ___ N ___	depression	Y ___ N ___
on walking		easy bruising	Y ___ N ___	irritability	Y ___ N ___
several blocks	Y ___ N ___	easy bleeding	Y ___ N ___	mood swings	Y ___ N ___
		swollen glands	Y ___ N ___	difficulty interacting	Y ___ N ___
<b>Endocrine</b>		blood clots	Y ___ N ___	drug/alcohol problems	Y ___ N ___
<i>no problems</i>	Y ___ N ___	tired without reason	Y ___ N ___		
diabetes	Y ___ N ___			<b>Lungs</b>	
thyroid problems	Y ___ N ___	<b>Genitourinary</b>		pneumonia	Y ___ N ___
brittle nails	Y ___ N ___	<i>no problems</i>	Y ___ N ___	pleurisy	Y ___ N ___
change in hair texture	Y ___ N ___	bedwetting	Y ___ N ___	collapsed lung	Y ___ N ___
change in skin texture	Y ___ N ___	frequent urination	Y ___ N ___	bronchitis	Y ___ N ___
premature puberty	Y ___ N ___	difficult urination	Y ___ N ___	last TB test	_____
delayed puberty	Y ___ N ___	yeast infection		Pos_____ Neg _____	
		on antibiotics	Y ___ N ___		
		accidental urination		<b>Liver</b>	
		with cough	Y ___ N ___	hepatitis	Y ___ N ___
				cirrhosis	Y ___ N ___

Other symptoms not listed above? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

21 Past Medical History - Have you had any of the following at any time in the past?:

Tuberculosis	Y ___ N ___	Hiatal Hernia	Y ___ N ___	epilepsy/seizures	Y ___ N ___
Positive TB test	Y ___ N ___	Ulcers	Y ___ N ___	congenital defects	Y ___ N ___
Migraine	Y ___ N ___	Irritable Bowel	Y ___ N ___	congenital heart	_____
Diabetes	Y ___ N ___	Crohn's Disease	Y ___ N ___	disease	Y ___ N ___
Cataracts	Y ___ N ___	lactose intolerance	Y ___ N ___	heart attack	Y ___ N ___
Glaucoma	Y ___ N ___	hepatitis	Y ___ N ___	angioplasty	Y ___ N ___
GERD	Y ___ N ___	arthritis	Y ___ N ___	bypass surgery	Y ___ N ___
stroke	Y ___ N ___	cancer	Y ___ N ___	abnormal stress test	Y ___ N ___
abnormal bone density	Y ___ N ___	osteoporosis	Y ___ N ___	drug addiction	Y ___ N ___
thyroid disease	Y ___ N ___	ADD/ADHD	Y ___ N ___	alcoholism	Y ___ N ___

(Graves, Hashimotos, thyroiditis, tumor, hyperthyroidism, hypothyroidism)

**PATIENT NAME:** \_\_\_\_\_

**For Children Specifically**

Birth complications Y ___ N ___	ADD Y ___ N ___	learning disability Y ___ N ___
Feeding problems Y ___ N ___	ADHD Y ___ N ___	growth delay Y ___ N ___
Adverse reactions to vaccines Y ___ N ___		developmental delay Y ___ N ___

Other medical problems not listed above: \_\_\_\_\_

List any surgeries with approximate dates: \_\_\_\_\_

22 <b>Family History</b>	Good Health	Asthma	Hayfever	Eczema	Food Allergies	Other Diseases
Mother	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___
Father	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___
Siblings (any)	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___
Offspring	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___	Y ___ N ___

Family history of cystic fibrosis? Y ___ N ___	Family history of glaucoma? Y ___ N ___
Family history of immune deficiency? Y ___ N ___	Family history of thyroid disease? Y ___ N ___

**23 Immunization History:**

Have you had chicken pox? Y \_\_\_ N \_\_\_ Or did you get vaccinated for it? Y \_\_\_ N \_\_\_

Are other childhood immunizations up to date? Y \_\_\_ N \_\_\_

Do you routinely receive a flu shot each fall? Y \_\_\_ N \_\_\_

When was your last TB skin Test? \_\_\_\_\_ Unknown \_\_\_\_\_

**24 Social History**

Marital Status M \_\_\_ S \_\_\_ D \_\_\_ W \_\_\_ N/A

Hobbies: \_\_\_\_\_

If in college, where and what primary field of study? \_\_\_\_\_

Your estimated alcohol consumption? \_\_\_\_\_

Who lives in your home? \_\_\_\_\_

If you are a minor: Are parents married and living together? Y \_\_\_ N \_\_\_

If not, are parents separated, divorced, or is a parent deceased? \_\_\_\_\_

Do you divide time between homes? \_\_\_\_\_

Explain \_\_\_\_\_

Does only one parent have legal custody? Y \_\_\_ N \_\_\_

Explain \_\_\_\_\_

**Any further comments?** \_\_\_\_\_

\_\_\_\_\_  
Signature of person completing form \_\_\_\_\_  
Date

P.A., N.P., M.D. REVIEW: \_\_\_\_\_

**SPECIAL INSTRUCTIONS**

All antihistamines and certain cough suppressants and antidepressants must be stopped for designated periods of time before testing. See "Medications to be Stopped" on our website. Check with the office if you have any doubt whether you may continue to take any given medication. Patients evaluated for HIVES and swelling should NOT discontinue medication. Please wear short sleeves. Please bring copies of any chest or sinus x-rays & CT scans with you. Office space is limited, please do not bring others with you. Please do not mail forms, just bring them with you. Thank you