

Patient's Name: _____ **Date:** _____

* Are you here for: Allergies Asthma Sinusitis Eczema Hives Other
(circle)

Yes No *Have you had a diagnostic evaluation for allergies prior to this visit?

Yes No *Have you had any previous skin testing?

Yes No *Do you have records?

Yes No *Have you ever or are you now on "allergy shots"?

Yes No *If "Yes", did they or are they working?

Yes No *Have you ever been diagnosed or treated for eczema?

I. Nasal Symptoms (circle) severe moderate mild

A. Symptoms

(circle)

Yes No *congested/stuffy/runs constantly/sniffles

Yes No *sneezing/itching/rubbing

Yes No *sinus trouble (headache, pressure, infections)

Yes No *discharge is clear/watery/thick/colored

Yes No *mouth breathing/snoring

Yes No *post nasal drainage

Yes No *bad breath

Yes No *problem with taste

Yes No *problem with smell

Yes No *teeth pain

Yes No *eye symptoms (itching, tearing, redness; light hurts)

Yes No *recent cold-approximate date: _____

Yes No *headaches occurring: _____ daily _____ weekly _____ monthly

*if yes, details _____

B. Sleeping

(circle)

Yes No *normal

Yes No *I wake during the night because of:

*congestion/runny nose/cough/short of breath/chest tightness

Yes No *In the morning, I have:

*congestion/runny nose/cough/short of breath/chest tightness

C. Time Frame/Seasonality

(circle)

1.) Nasal symptoms are present:

Yes No (a) year round without any seasonal change

Yes No (b) year round, but get worse at certain times

Yes No (c) only at certain times of the year

2.) If the answer to (b) or (c) above was “yes”, which months are symptoms either present or appreciably worse?

(circle)

Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

3.) Nasal symptoms have been present

Yes No *more than 10 years

Yes No *3-10 years

Yes No *less than 3 years

Yes No *recent X-ray/CT scan of sinuses

*Are you having:

*recurrent sinus infection? Yes No

*last infection ___/___(month/year)

*antibiotics used? _____

*Have you had sinus surgery? ___/___
(month/year)

4.) Symptoms over the years are:

Yes No *generally better than 6 years ago

Yes No *generally getting worse each year

Yes No *about the same

5.) Do you have:

Yes No *recurrent upper respiratory infection?

Yes No *recurrent ear infections?

D. Nasal symptoms seem to be brought on or worsened by:

Yes No *pollens

Yes No *pet exposures (if “Yes”, which: _____)

Yes No *dust

Yes No *mowing grass/gardening/weeds

Yes No *raking leaves/compost

Yes No *damp basements

Yes No *cigarette smoke

Yes No *fumes (chemical, smog, auto exhaust)

Yes No *weather changes (temperature, barometric pressure)

E. Recent medications you are using:

Yes No *antihistamines *nasal steroids Yes No

Yes No *Do they work? *Do they work? Yes No

II. Chest Symptoms (circle one) Severe Moderate Mild

Yes No 1.) Have you ever “wheezed”, had asthma, or asthmatic bronchitis?

*If the answer to #1. Was yes, indicate when:

Yes No *only prior to age 12

Yes No *in childhood and more recently

Yes No *more recently

Yes No 2.) Do you sometimes get a sensation of chest tightness, shortness of breath, spasmodic "tight coughing, and/or wheezing?
 Yes No *chronic/ongoing
 Yes No *intermittent/infrequent

3.) Chest symptoms will be brought on by:
 Yes No *head colds/URI's/viral infections
 Yes No *dust exposure
 Yes No *animal exposures
 Yes No *pollen exposures
 Yes No *exercise
 Yes No *cold air exposures
 Yes No *cigarette smoke exposures
 Yes No *exposure to odors (perfumes, gasoline, etc.)
 Yes No *weather changes (temperature, barometric pressure)

		4.) Because of chest symptoms <u>THIS YEAR</u> , did you:	<u>LAST YEAR</u>
Yes	No	*need to go to the emergency room	Yes No
Yes	No	*need hospitalization	Yes No
Yes	No	*use inhalers	Yes No
Yes	No	*use steroids	Yes No
Yes	No	*need chest x-ray	Yes No
Yes	No	*get pneumonia	Yes No
Yes	No	*get bronchitis	Yes No

5.) When present, chest symptoms occur in: (circle one)
 Morning Evening Night Variable

6.) When present, chest symptoms occur: (circle one)
 Seldom Occasionally Always

Yes No 7.) Do (or have) you smoke (d)? If yes indicate age and when started/stopped.
 Yes No 8.) Do you produce mucus/phlegm with coughing?
 Yes No 9.) Do you have chest discomfort or heartburn with meals or position changes (sitting or lying down)?
 Yes No 10.) Do you have chest pain or heartburn associated with shortness of breath, cough or chest tightness?

Yes No 11.) Do you have: Reflux Disease/Peptic Ulcer Disease/ Hiatal Hernia
 *If answered "Yes" to any of question #11, list current meds. _____

*Do the current medications work? Yes No

A. Cardiac Symptoms

1.) Have you ever been diagnosed as having/had:
 Yes No * High Blood Pressure
 Yes No * Heart Murmur

- Yes No * Stroke
- Yes No * Heart Attack
- Yes No * Swollen Ankles
- Yes No * Leg Pain (walking)
- Yes No * Varicose Veins
- Yes No * Foot Pain (cold/numb)
- Yes No * Dizziness/Fainting
- Yes No * Arm/Leg Weakness
- Yes No * Numbness/Tingling
- Yes No * Poor Circulation
- Yes No * Irregular Heart Beat

Please Describe: _____
 Treatment: _____

III. Skin Symptoms

- Yes No 1.) Do you have any contact allergy (e.g.latex,metal,cosmetic,soap,lotion)
- Yes No 2.) Have you ever had eczema or allergic skin problems?
 Explain _____
- Yes No 3.) Have you been using skin creams? If yes, please describe. _____
- Yes No 4.) Are you taking antihistamines for this problem? If yes, please describe _____
- Yes No 5.) Is the eczema getting better or worsening?
 Describe _____
- Yes No 6.) Have you seen a doctor about this problem?
 Describe _____

IV Miscellaneous Symptoms

- Yes No 1.) Do you have any known drug allergy? Describe: _____
- Yes No 2.) Do you have any known food allergy? Describe: _____
- Yes No 3.) Do you have any stinging insect allergy? Describe: _____
- Yes No 4.) Have you ever had hives?
- Yes No 5.) Are there any family members with: allergies asthma sinusitis?(circle)
- Yes No 6.) Does your occupation involve exposure to fumes, dusts, or chemicals?
- Yes No 7.) Are your symptoms better or worse at work (than at home)? If yes, which? _____

V. Environment

Occupation: _____
 (circle one)

- Yes No 1.) Living quarters is a: house apartment dorms other

- Yes No 2.) Heating system has: forced air heat hot water heat other
- Yes No 3.) Cooling system has: window a/c's central a/c's evaporative cooler
- Yes No 4.) Are there pets at home? If yes, what kind? _____
- Yes No 5.) Are there smokers at home? If yes, who? _____
- Yes No 6.) Is there a basement in the home? If yes, is it? _____
 *finished Yes No *dry Yes No
 *unfinished Yes No *damp/musty Yes No
- 7.) In the bedroom, are there
- Yes No *wall-to-wall carpet
- Yes No *feather or down pillows
- Yes No *regular (cotton) mattress/box spring sets
- Yes No *venetain blinds or lined drapes on windows
- Yes No *wool blankets or down comforters on the bed
- Yes No *humidifers