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Please review the **Medications to Avoid** handout also on the website prior to your visit.

Patient Name: _____ DOB: _____ Referring Physician: _____

Describe the reason for your visit and what problems or symptoms you are having:

-
-
-

Check all symptoms below you have experienced:

Head/Nose/Throat	Eyes	Respiratory/Chest	Skin
<input type="checkbox"/> Sneezing <input type="checkbox"/> Nose blockage <input type="checkbox"/> Runny nose <input type="checkbox"/> Sinus infection <input type="checkbox"/> Drainage <input type="checkbox"/> Postanasal drip <input type="checkbox"/> Sore throat <input type="checkbox"/> Ear blockage <input type="checkbox"/> Headache <input type="checkbox"/> hoarseness <input type="checkbox"/> Loss of voice	<input type="checkbox"/> Red eyes <input type="checkbox"/> Watery eyes <input type="checkbox"/> Itchy eyes <input type="checkbox"/> Swollen eyes <input type="checkbox"/> Dry eyes	<input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest infection(s)	<input type="checkbox"/> Hives <input type="checkbox"/> Eczema <input type="checkbox"/> Itching <input type="checkbox"/> Swelling

Approximately how many years have you suffered from the above symptoms:

Head/Nose/Throat _____ Eyes _____ Respiratory/Chest _____ Skin _____

If you have experienced a reaction to an insect sting, food, or drug please check symptoms below in the appropriate column:

Insect Sting	Food Reaction	Drug Reaction
<input type="checkbox"/> Cough <input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Dizziness <input type="checkbox"/> Passing out <input type="checkbox"/> Other	<input type="checkbox"/> Cough <input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Dizziness <input type="checkbox"/> Passing out <input type="checkbox"/> Other	<input type="checkbox"/> Cough <input type="checkbox"/> Hives <input type="checkbox"/> Swelling <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Dizziness <input type="checkbox"/> Passing out <input type="checkbox"/> Other

Do you note increased symptoms from any of the following?

Allergens	Irritants	Weather changes	Ingestants	Miscellaneous
<input type="checkbox"/> Tree pollen <input type="checkbox"/> Mowed grass <input type="checkbox"/> Hay <input type="checkbox"/> Weeds <input type="checkbox"/> House dust <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Feather <input type="checkbox"/> Mold	<input type="checkbox"/> Perfumes <input type="checkbox"/> Soaps <input type="checkbox"/> Detergents <input type="checkbox"/> Smoke <input type="checkbox"/> Paint <input type="checkbox"/> Hair spray <input type="checkbox"/> Outside dust	<input type="checkbox"/> Windy days <input type="checkbox"/> Cold fronts <input type="checkbox"/> Damp weather <input type="checkbox"/> Temperature changes	<input type="checkbox"/> Medications <input type="checkbox"/> Foods <input type="checkbox"/> Alcohol	<input type="checkbox"/> Colds <input type="checkbox"/> Virus <input type="checkbox"/> Physical exertion

If you marked **YES** to an ingestant above, please list the specific ingredient that caused the symptoms:

How long have you had your symptoms? _____

Are they getting worse? YES NO

Are your symptoms (check one):

- Year round with no seasonal variation?
- Year round with seasonal worsening?
- Seasonal only?

Circle the months that you experience symptoms:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

List all medications that you use for Allergy/Asthma symptoms (pills, drops inhalers, sprays, creams):

List any other drug that you take regularly for any reason. Please include all over the counter drugs:

List any medical condition(s) for which you are currently being treated or have been treated for in the past:

Previous Surgeries:

- Sinus surgery: YES NO
- Tubes in ears: YES NO
- Tonsils/Adenoids removed: YES NO

Have you ever been hospitalized for asthma or an allergic reaction? YES NO

If yes, what for? _____

Are your Immunizations up-to-date? YES NO

If no, please list immunizations still needed: _____

Have you had allergy skin testing previously? YES NO

Have you taken allergy shots previously? YES NO

Are you still taking them? YES NO

If no, how long did you receive allergy shots? _____ When did you stop? _____

Do you have pets at home? YES NO If yes, what kind? _____

Indicate if pets are : Kept outside at all times Kept both in and out Kept inside mostly

How long has it been since you had a chest X-ray? _____

Have you ever had a sinus X-ray? YES NO If yes, when? _____ Results? _____

Do you currently smoke? YES NO Packs per day? _____ How long? _____

If no, did you smoke in the past? YES NO How long? _____ When did you quit? _____

Are you regularly exposed to second hand smoke? YES NO

Can you take Aspirin? YES NO

Do your symptoms disturb your sleep? YES NO

Do you have carpeting or a fan in your bedroom? Carpet Fan Neither Both

Do you use a humidifier? YES NO

Do you know if you have been exposed to mold? YES NO If yes, when? _____

Is there a history of any of the following conditions in your family?

Condition		Relative (ex.mother, father, sibling, grandparent, etc.)
Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Hay Fever/Nasal Allergies	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Eczema	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Hives	<input type="checkbox"/> YES <input type="checkbox"/> NO	
Autoimmune conditions (Thyroid, Lupus, Rheumatoid, Type I Diabetes)	<input type="checkbox"/> YES <input type="checkbox"/> NO	

Other comments you wish to review?
