

Date: _____ Referred by: _____

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ For how long? _____

Social Security #: _____

Main Complaint: _____

Prior Allergy Treatment or Testing: YES NO (If yes, where and when?) _____

Other Medical Problems: _____

List Major Surgeries and Dates: _____

List ALL medications now being taken: _____

CHECK ALL SYMPTOMS YOU HAVE EXPERIENCED:

NOSE: itching sneezing nasal congestion (stuffy) runny nose post nasal discharge
 redness frequent "colds" polyps sinus trouble sinus infections (____ # per year)

EYES: itching outer corner itching inner corner puffiness blurred vision
 excessive tearing dark circles under eyes discharge visual disturbances

EARS: itching itching deep in ears tinnitus (ringing) dizziness popping
 fullness pressure hearing loss drainage (discharge) red
 frequent infections (_____ # per year)

MOUTH & THROAT: frequent sore throats itching of palate or back of throat difficulty swallowing
 lump sensation laryngitis need to clear mucous in the morning mouth ulcers
 swelling of lips swelling of tongue scratchy or burning sensation

CHEST: Cough wheezing shortness of breath pain tightness asthma
 frequent chest colds or infections chronic obstructive pulmonary disease (COPD)
 frequent attacks of bronchitis (_____ # per year)

GASTRO-
INTESTINAL: belching bloating heartburn retasting of foods cramping bad breath
 excessive gas diarrhea constipation poor appetite irritable bowel syndrome

- GENTRO-URINARY: difficulty voiding frequency urgency burning prostatitis vaginitis
 itching frequent urinary infections frequent yeast infections
- SKIN: hives rashes eczema swelling itching reactions to cosmetics
 blisters or peeling of hands athlete's foot jock itch
- NEUROLOGICAL: headache (sinus migraine tension) decreased attention span
 learning disability seizures inability to concentrate poor memory
- MISCELLANEOUS: joint pain muscle pain arthritis restless legs chronic fatigue
 insomnia

ANSWER ALL QUESTIONS BELOW WHICH PERTAIN TO YOU:

Seasonal Incidence:

Do you have trouble or is your condition worse:

1. In the Spring Yes No
 2. In the Summer Yes No
 3. In the Fall Yes No
 4. In the Winter Yes No

Describe your allergy "attack" symptoms:

5. Do your attacks last
 A few minutes Yes No
 Several hours Yes No
 Several days Yes No
 A whole season Yes No
 The whole year Yes No
 6. Do the attacks occur regularly at a particular time of day or night? Yes No
 7. Have you found anything which will relieve attacks? Yes No
 8. Will the attacks cause you to lose sleep? Yes No
 9. Will the attacks interrupt your daily routine? Yes No

Childhood History:

10. Did you have eczema? Yes No
 11. Did you have colic? Yes No
 12. Were you often sick? Yes No
 13. Did you have bronchitis or asthma? Yes No
 14. Did you have croup? Yes No
 15. Did you have frequent attacks of "stomach ache", diarrhea or vomiting? Yes No
 16. Did you have frequent colds? Yes No
 17. Did you have frequent ear infections? Yes No
 18. Did you have sinus trouble? Yes No
 19. Did you have frequent sore throats? Yes No

Family History:

Have any members of your family (this includes mother, father, grandparents, aunts, uncles, brothers, sisters and children) had any of the following diseases:

20. Asthma Yes No
 21. Hay Fever Yes No
 22. Nasal allergy (frequent attacks of sneezing, runny nose, blockage of nose, post nasal drip) Yes No
 23. Hives Yes No
 24. Eczema Yes No
 25. Chronic skin disease Yes No
 26. Frequent headaches Yes No
 27. Migraine Yes No

Non-pollen Inhalant History:

House Dust:

Do you notice that your trouble begins or is aggravated:

- 28. When the house is being cleaned or swept..... Yes No
- 29. When rugs are being cleaned..... Yes No
- 30. When the bed is being made or the mattress being turned..... Yes No
- 31. During spring house cleaning..... Yes No
- 32. When you sit on old, overstuffed furniture..... Yes No
- 33. In such dusty places as: theaters, churches, grocery stores, department stores, libraries, your bedroom... Yes No

Atmospheric Mold:

Do you notice that your trouble begins or is aggravated:

- 34. During prolonged periods of damp or humid weather..... Yes No
- 35. When you are around where grass is being mowed or weeds are being cut..... Yes No
- 36. When you are near hay or straw (as at the circus, in a barn, around a hay stack, on a hay ride) Yes No
- 37. When you go into an old damp house, a damp basement, shed or cellar..... Yes No
- 38. When you enter a closet in which are stored old shoes, unused luggage, gloves or other leather goods) .. Yes No
- 39. If you eat cheese, mushrooms, cantaloupe or drink beer..... Yes No
- 40. When the first cold snap of autumn..... Yes No

Animals:

Do you notice that your trouble begins or is aggravated:

- 49. When lying on a feather pillow..... Yes No
- 50. When fluffing pillows..... Yes No
- 43. If you use a down comforter..... Yes No
- 44. If you are near chickens, ducks, geese, pigeons, parrots, turkeys, canaries or other birds..... Yes No
- 45. If you are around anyone who works around poultry or other fowl..... Yes No
- 46. Do you have pets in the house or yard?..... Yes No
- 47. When you are around any of the following animals: dogs, cats, horses, goats, rabbits, cows, hogs or sheep. Yes No
- 48. When you handle or come into contact with any of the following: furs, rugs, certain articles of clothing, dress goods, blankets, gloves, hats, toy animals or brushes..... Yes No

Smoke:

Do you notice that your trouble begins or is aggravated:

- 49. Do you smoke?..... Yes No
- 50. When you are in night clubs or other smoky places..... Yes No

Orris Root:

Do you notice that your trouble begins or is aggravated:

- 51. When using face, talcum, body, bath or tooth powder..... Yes No
- 52. In beauty parlors or barber shops..... Yes No
- 53. When you are around people who use a lot of powder or perfume..... Yes No

Pyrethrum-Orris Root-Lethane-Paradichlorobenzene:

Do you notice that your trouble begins or is aggravated:

- 54. When you are exposed to household insect powders or sprays..... Yes No
- 55. When you are exposed to powders, sprays or crystals used for mothproofing purposes..... Yes No
- 56. When you are exposed to dusting powders or sprays used in the gardens or on crops..... Yes No

Food History:

- 57. Do you suspect any food in causing or aggravating your condition? Yes No
- 58. Are there any foods which you dislike? Yes No
- 59. Are there any foods in which you over-indulge or eat frequently because you like them so much? ... Yes No
- 60. Is there any seasonal food (for example strawberries) in which you over-indulge? Yes No
- 61. Are there any foods you find difficult to digest? Yes No
- 62. Do any foods you eat cause nausea, vomiting, diarrhea, heartburn, belching, gas on the stomach, cramps, hives, skin rashes, headaches? (check all those that apply)..... Yes No
- 63. Are you on any type of diet at present?..... Yes No

Physical History:

Does your trouble at times seem to begin or become aggravated

- 64. By change in the weather Yes No
- 65. By exercise Yes No
- 66. By fatigue..... Yes No
- 67. By loss of sleep Yes No
- 68. By excitement..... Yes No
- 69. By emotional upheaval Yes No
- 70. By a hot or cold bath..... Yes No
- 71. By becoming overheated..... Yes No
- 72. By prolonged periods of physical or mental work or prolonged stress (as when there is someone sick in the family) Yes No
- 73. As a result of "nervousness" Yes No
- 74. Air conditioning Yes No

Focal Infection History:

- 75. Are you conscious of a foul odor in your nose?..... Yes No
- 76. Do you have a dripping from the back of your nose into your throat which has a "sickening sweet" taste or is yellow or green like pus? Yes No

Environmental Survey: (home survey)

- 77. Is your house old? Yes No
- 78. Is your house new? Yes No
- 79. Is your house damp? Yes No
- 80. Is your house dry? Yes No
- 81. Do things mildew easily around the house? Yes No
- 82. Near your house, is there:
 - a factory Yes No
 - a railroad..... Yes No
 - a lake Yes No
 - a poultry yard..... Yes No
 - a swampy area Yes No
 - lots of weeds..... Yes No
 - anything you suspect as a possible cause of your symptoms..... Yes No
- 83. Is your house heated by:
 - Open gas heaters Yes No
 - Floor gas furnaces..... Yes No
 - Radiators Yes No
 - Open fireplaces Yes No
 - Central heating system with ducts..... Yes No
- 84. Is your house cooled by:
 - An attic fan..... Yes No
 - Window air-conditioning Yes No
 - Central air-conditioning..... Yes No
 - Window fans Yes No
- 85. Do you have plants in the house or in window planter boxes? Yes No

- 86. Do you use insect sprays or moth repellents in the house? Yes No
- 87. Do you keep any books or magazines that gather dust in the house? Yes No
- 88. Do you have overstuffed furniture? Yes No
- 89. Do you use feather pillows? Yes No
- 90. Do you use down comforters on the bed? Yes No
- 91. Do you have rugs on the floor? Yes No
- 92. Do you use padding under your rugs? Yes No
- 93. Do you have draperies on the windows? Yes No
- 94. Do you have throw pillows around the house? Yes No
- 95. Are there any smells or fumes continuously or frequently present about the house? Yes No
- 96. Is there any place in the house where you have symptoms regularly? Yes No
- 97. Are the walls in your house covered with wallpaper? Yes No
- 98. Is there any type of business enterprise carried out in your house? Yes No
- 99. Are you engaged in a hobby in your house? Yes No

Work or School Survey

- 100. Do you have symptoms at work or school? Yes No
- 101. Is the place where you work or attend school: Yes No
 - damp Yes No
 - cooled with window or attic fans Yes No
 - air-conditioned Yes No
 - centrally heated Yes No
 - dusty Yes No
 - smoky Yes No
- 102. As far as you know, do you inhale anything at work or school which might cause or aggravate your symptoms? Yes No
- 103. Are there fumes, gases, smokes or odors where you work or attend school? Yes No

Activities

- 104. Do you take part in any outdoor sports or hobbies? Yes No
- 105. Are you better when you are away from home on a trip, such as vacation time? Yes No

Previous Treatment History:

- 106. Have you ever had any operations for your condition? Yes No
- 107. Have any of the treatments or drugs prescribed given prolonged relief? Yes No

GENERAL MEDICAL HISTORY

1. Do you often have pain in the face? Yes No
2. Do you often experience flushing of the face with a sensation of warmth? Yes No
3. Do you often suffer pains in the eyes: Yes No
4. Do you experience a sense of burning or dryness in the nose or sense of stuffiness, rather than actual blockage? Yes No
5. Do you often have pain inside of your nose? Yes No
6. Are you bothered with a bad odor inside your nose? Yes No
7. Do you frequently blow large, dried crusts or scabs from your nose? Yes No
8. Have you ever had severe nosebleeds? Yes No
9. Have you ever fallen or been hit hard on the nose? Yes No
10. Has your nose ever been broken? Yes No
11. Have you ever been told that you had a crooked bone in your nose? Yes No
12. Have you ever had an operation on your nose or sinuses? Yes No
13. Are you bothered by a soreness or burning in your mouth? Yes No
14. Do you have bad breath at times? Yes No
15. Are you often bothered with a sensation of dryness in your mouth? Yes No
16. Is your tongue often sore? Yes No
17. Do you often find yourself grinding your teeth or do people tell you that you grind your teeth while sleeping? Yes No
18. Do you often have pain around your ears when you chew? Yes No
19. Do the glands in your neck swell when you get sore throats?
20. Have your tonsils been removed? Yes No
21. Did you ever have to take a breathing test? Yes No
22. Do you have chronic chest trouble (except asthma)? Yes No
23. Did you ever have T.B. (tuberculosis)?
24. Do you live with anyone who has had T.B.? Yes No
25. Did you ever have a chest or lung operation? Yes No
26. Did the doctor say that you have heart trouble? Yes No
27. Do you have high blood pressure? Yes No
28. Do you have low blood pressure? Yes No
29. Do your hands and feet swell badly? Yes No
30. Do you get short of breath easy? Yes No
31. Does your heart ever beat so fast and hard that it seems to shake your chest?
32. Do you frequently get leg cramps? Yes No
33. Is your appetite poor? Yes No
34. Have you lost weight lately? Yes No
35. Do you gain weight easily? Yes No
36. Have you ever had stomach ulcers? Yes No
37. Did you ever have rheumatic fever? Yes No
38. Do you seem to get tired faster than the average person? Yes No
39. Are you sick often? Yes No
40. Did a doctor say you were anemic? Yes No