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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
☐ Sneezing	☐ Red eyes	☐ Cough	☐ Hives
☐ Nose blockage	☐ Watery eyes	☐ Wheezing	☐ Eczema
☐ Runny nose	☐ Itchy eyes	☐ Shortness of breath	☐ Itching
☐ Sinus infection	☐ Swollen eyes	☐ Chest infection(s)	☐ Swelling
☐ Drainage	☐ Dry eyes		
☐ Post nasal drip			
☐ Sore throat			
☐ Ear blockage			
☐ Headache			
☐ Hoarseness			
☐ Loss of voice			

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

Head/Nose/Throat ___ years Eyes ___ years Respiratory/Chest ____ years Skin ____ years

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
☐ Cough	☐ Cough	☐ Cough
☐ Hives	☐ Hives	☐ Hives
☐ Swelling	☐ Swelling	☐ Swelling
☐ Shortness of breath	☐ Shortness of breath	☐ Shortness of breath
☐ Wheezing	☐ Wheezing	☐ Wheezing
☐ Dizziness	☐ Dizziness	☐ Dizziness
☐ Passing out	☐ Passing out	☐ Passing out
☐ Other	☐ Other	☐ Other

If you marked **YES** to an allergen above, please list the specific trigger of the symptoms:

Insect Sting specific insect	Food(s) involved in the reaction	Drugs involved in the reaction

Do you note increased symptoms from any of the following?

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

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?

Mark 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(s) 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

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

Condition		Relative (ex.mother, father, sibling, grandparent, etc.)
Asthma	☐ YES ☐ NO	
Hay Fever/Nasal Allergies	☐ YES ☐ NO	
Eczema	☐ YES ☐ NO	
Hives	☐ YES ☐ NO	
Autoimmune conditions (Thyroid, Lupus, Rheumatoid, Type I Diabetes)	☐ YES ☐ NO	

Other comments you wish to review?

_____