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Patient's Name: _____ Age: _____ Today's Date _____

Check your main symptoms:

- | | | |
|---|---|---------------------------------------|
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> headache | <input type="checkbox"/> sore throats |
| <input type="checkbox"/> runny nose | <input type="checkbox"/> itchy, watery eyes | <input type="checkbox"/> hoarseness |
| <input type="checkbox"/> stuffy nose | <input type="checkbox"/> asthma | <input type="checkbox"/> skin rashes |
| <input type="checkbox"/> post nasal-drainage | <input type="checkbox"/> cough | <input type="checkbox"/> eczema |
| <input type="checkbox"/> sinus infections | <input type="checkbox"/> chest infections | <input type="checkbox"/> itchy skin |
| <input type="checkbox"/> blocked or infected ears | <input type="checkbox"/> stomach or intestinal distress | <input type="checkbox"/> hives |

How long have you been having these symptoms? _____

Are they worse at certain times of the year? _____ at different times of the day? _____

Are they worse or better when you travel elsewhere? _____

What are you currently taking for your symptoms? _____

What medicines have you taken that did *not* help or had side effects? _____

How much school or work have you missed this year due to this problem? _____

Do you have a family history of allergies? (If yes, who and what type?) _____

Home Environment Check the boxes that describe your home.

- | | | | |
|-------------------------------------|---|---|--|
| <input type="checkbox"/> dogs | <input type="checkbox"/> central heat/air | <input type="checkbox"/> venetian blinds | <input type="checkbox"/> some damp areas |
| <input type="checkbox"/> cats | <input type="checkbox"/> new home | <input type="checkbox"/> lots of house plants | <input type="checkbox"/> fluffy comforters/blankets |
| <input type="checkbox"/> other pets | <input type="checkbox"/> older home | <input type="checkbox"/> lots of books | <input type="checkbox"/> someone smokes |
| <input type="checkbox"/> carpeted | <input type="checkbox"/> ceiling fans | <input type="checkbox"/> lots of magazines | <input type="checkbox"/> my bathroom is attached to my bedroom |

Work or School Environment:

If you work outside the home, check the boxes that describe your work.

- | | | |
|--|---|---|
| <input type="checkbox"/> office building | <input type="checkbox"/> good ventilation system | <input type="checkbox"/> I feel better at work |
| <input type="checkbox"/> outdoors | <input type="checkbox"/> older ventilation system | <input type="checkbox"/> I feel worse at work |
| <input type="checkbox"/> retail | <input type="checkbox"/> fans are used a lot | <input type="checkbox"/> solvents/odors at work |
| <input type="checkbox"/> factory | <input type="checkbox"/> people smoke a lot | <input type="checkbox"/> it is dusty at work |

Do you seem to react to foods? (Which ones?) _____

Do weather changes bother you? _____

Do irritants (perfumes, cigarette smoke, hairspray, paint, etc.) aggravate your symptoms? _____

Are you allergic to drugs or insect stings? (Describe reactions.) _____

I have had skin tests before. I have taken shots before. The shots helped a lot / a little / not at all (circle one).

List all medication you take on a regular basis: _____

Do you smoke? _____

Do you have high blood pressure? _____

Do you have heart trouble? _____

Do you have diabetes? _____

List any hospitalizations you have had

List places you have lived:

Ages or Years

Age or Year Reason for Hospitalization

Age or Year	Reason for Hospitalization	Places Lived	Ages or Years