

PATIENT NAME:

Date:

SYMPTOMS

- Sneezing
- Watery eyes
- Runny nose
- Blocked nose
- Post Nasal Drip
- Headaches (all types)
- Itching of the nose
- Itching of the eyes
- Itching of the ears
- Itching of the mouth
- Shortness of breath
- Chest Congestion
- Coughing
- Wheezing
- Swelling of eyelids
- Swelling of the lips
- Swelling of the body
- Hives
- Rash or Eczema
- Fatigue
- Nausea
- Diarrhea
- Stomach cramps

Please review these questions as they apply to the symptoms which you have checked:

When did these symptoms first occur?

How often and when do the symptoms occur?

How severe are they?

How long do they last?

MEDICAL HISTORY

Have you ever had?

- Hay fever
- Croup
- Bronchitis
- Asthma
- Hives
- Other skin rashes
- Sensitivity to foods
- Sensitivity to drugs
- Sensitivity to insect stings
- Skin tests
- Allergy shots
- Alternative treatments (e.g. herbal therapy or acupuncture)

MEDICATION

List all over the counter medications, prescription medications and herbal products you are currently taking:

List any medications you have taken in the last year that is not on current medication list:

List any medications that you are allergic to:

HOME ENVIRONMENT

Does your house have:

- Central Air Condition
 - Window A/C Units
 - Gas furnace
 - Electric furnace
 - A basement
 - Carpeting
 - Plants
 - Does any household member or regular visitor smoke?
- Do you have a:
- Cat Dog Bird
 - Other _____

MEDICAL HISTORY

List any medical conditions you have:

FAMILY HISTORY

Do any of these members of your family have allergies:

- Mother Father
- Grandparent(s)
- Sister(s) Brother(s)
- Other relatives

List any other conditions that tend to run in your family (diabetes, high blood pressure, etc.):