



Patient Name: _____

Date: _____

Address: _____

Date of Birth: _____

City, State, Zip: _____

Home#: _____

Gender (circle one): **MALE** **FEMALE**

Work#: _____

Primary Care Physician: _____

Referring Physician: _____

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single “healthy” diet that will work for everyone.*
- *Just because food is considered “healthy”, does not mean it is “healthy” for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale.***
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish: _____

AGE WHEN SYMPTOMS WERE FIRST OBSERVED

- | | |
|--|---|
| <input type="checkbox"/> Infant (Age 0-2) | <input type="checkbox"/> Child (Age 3-5) |
| <input type="checkbox"/> Child (Age 6-12) | <input type="checkbox"/> Adolescent (Age 13-18) |
| <input type="checkbox"/> Adult (Age 19-25) | <input type="checkbox"/> Adult (Age 26-40) |
| <input type="checkbox"/> Adult (Age 41 and over) | |

DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED? _____

HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME? _____

PREVIOUS DIAGNOSIS OF ALLERGY

- Yes and allergy shots helped
- Yes but allergy shots did not help
- Yes and medication helped
- Yes but medication did not help
- None

FAMILY MEMBERS WITH ALLERGIC SYMPTOMS

- Mother
- Father
- Brother/Sister
- Grandparents
- Son/Daughter
- Spouse
- None

FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS

- Constant/Chronic with little change
- Present most of the time
- Present part of the time
- Present rarely
- Prevents some normal activities
- Considerable interference with normal life
- Slight interference with normal life
- No interference with normal life

SYMPTOMS ARE WORSE

- Outdoors and better indoors
- At nighttime
- In the bedroom or when in bed
- During windy weather
- During wet or damp weather
- When the weather changes
- During known pollen seasons
- In certain rooms or buildings
- When exposed to tobacco smoke
- With yard work, cut grass, leaves, hay or barns
- When sweeping or dusting the house
- In areas with mold or mildew
- In air conditioning
- In fields or in the country
- Tobacco smoke bothers me more than anything else

SYMPTOMS ARE BETTER

- After shower or bath
- In air conditioning
- Indoors
- During or after physical activity
- After taking antihistamines
- With allergy shots

What makes you feel better? _____

ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE

- Dogs
- Cats
- Rodents (mice, guinea pigs, etc.)
- Horses or Cattle
- Rabbits
- Birds or Feathers
- Bees
- Other _____
- None

FOOD RELATED SYMPTOMS

- Symptoms flare 5-60 minutes after meals
- The smell or odor of some foods increases symptoms
- Some foods cause swelling of the mouth or tongue
- Some foods cause upset stomach or vomiting
- Symptoms occur with restaurant salad bars or Asian foods
- Symptoms occur with any regularly eaten food
- Preservatives, additives or food coloring increase symptoms
- Some foods are craved or addictive
- Some foods cause nasal symptoms
- Some foods cause rashes or hives
- Some foods cause diarrhea
- Some foods cause headaches
- Some foods cause asthma
- No problem with foods

FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

- | | | |
|--|---|------------------------------------|
| <input type="checkbox"/> Eggs | <input type="checkbox"/> Milk | <input type="checkbox"/> Beef |
| <input type="checkbox"/> Corn | <input type="checkbox"/> Wheat | <input type="checkbox"/> Soybean |
| <input type="checkbox"/> Peanut | <input type="checkbox"/> Pork | <input type="checkbox"/> Fish |
| <input type="checkbox"/> Shellfish | <input type="checkbox"/> Orange or other citrus | <input type="checkbox"/> Potato |
| <input type="checkbox"/> Tomato | <input type="checkbox"/> Yeast | <input type="checkbox"/> Chocolate |
| <input type="checkbox"/> Coffee or Tea | <input type="checkbox"/> Other _____ | |
| <input type="checkbox"/> None | | |

CHEMICALS THAT CAUSE SYMPTOMS

- | | |
|---|---|
| <input type="checkbox"/> Insecticides & pesticides | <input type="checkbox"/> Paints & household cleaners |
| <input type="checkbox"/> Perfumes & cosmetics | <input type="checkbox"/> Gasoline or automobiles exhaust |
| <input type="checkbox"/> Stove or furnace emissions | <input type="checkbox"/> The smell of new fabrics or fabric store |
| <input type="checkbox"/> Chemicals in the workplace | <input type="checkbox"/> Laundry detergent |
| <input type="checkbox"/> Newsprint | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> None | |

WHEN ARE YOUR SYMPTOMS WORSE

- | | | | |
|------------------------------------|-----------------------------------|--------------------------------------|-----------------------------------|
| <input type="checkbox"/> January | <input type="checkbox"/> February | <input type="checkbox"/> Year around | |
| <input type="checkbox"/> May | <input type="checkbox"/> June | <input type="checkbox"/> March | <input type="checkbox"/> April |
| <input type="checkbox"/> September | <input type="checkbox"/> October | <input type="checkbox"/> July | <input type="checkbox"/> August |
| | | <input type="checkbox"/> November | <input type="checkbox"/> December |

MEDICATIONS

Do you take any of the following medications on a regular basis?

- Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc)
- Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc)
- Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc)
- Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)
- Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)
- Chemotherapy

Please list any medications that you are currently taking: _____

SMOKING

Do you presently smoke? Yes No If yes, average number of cigarettes per day _____

If yes, at what age did you start? _____

Does anyone smoke in your home? Yes No

PREVIOUS ALLERGY EVALUTION

Have you ever seen an allergist? Yes No

Have you had allergy skin testing? Yes No

Did you have any positive reaction? Yes No

If yes, please list positive allergens (include any medications) _____

Have you ever received allergy injections? Yes No

WORK ENVIRONMENT

What is your occupation? _____

Are you exposed to chemicals or strong odors at work? Yes No

If yes, briefly explain _____

Are you symptoms worse while at work? Yes No

If yes, briefly explain _____

ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW? _____

ANYTHING ELSE YOU WOULD LIKE TO ASK? _____
