CHART #:_______________

NAME: ____ DOB: ______________________

TODAY'S DATE: ________________________ PATIENT TESTING DATE: ________________________

REFERRING PHYSICIAN: ____

AGE: ______ AGE WHEN SYMPTOMS BEGAN: ______

SYMPTOMS: *(Indicate from the list below)*

- ❑ Cough
- ❑ Nasal congestion
- ❑ Red/watery eyes
- ❑ Headaches/migraines
- ❑ Nausea
- ❑ Colds
- ❑ Wheezing
- ❑ Itchy mouth
- ❑ Frequent Infections
- ❑ Fever
- ❑ Indigestion
- ❑ Sneezing
- ❑ Hoarseness
- ❑ Dizziness
- ❑ Fatigue
- ❑ Stress
- ❑ Diarrhea
- ❑ Runny nose
- ❑ Scratchy throat
- ❑ Ears popping
- ❑ Rashes/hives
- ❑ Abdominal pain/gas

List your top three symptoms starting with the most bothersome.

1. __________________________ 2. __________________________ 3. __________________________

FREQUENCY/TIME OF SYMPTOMS: *(Check corresponding boxes below)*

______ Sporadic (at various times of year but with no pattern)

______ Persistent (throughout the year)

______ Seasonal (indicate the prominent months below)

- ❑ Jan
- ❑ Feb
- ❑ March
- ❑ April
- ❑ May
- ❑ June
- ❑ July
- ❑ Aug
- ❑ Sept
- ❑ Oct
- ❑ Nov
- ❑ Dec

SURROUNDINGS: *(Indicate where/when symptoms occur)*

- ❑ After mowing
- ❑ In damp areas
- ❑ While driving
- ❑ Out walking
- ❑ While exercising
- ❑ By burning leaves
- ❑ Near farms
- ❑ Sitting on furniture
- ❑ Reading a book
- ❑ At school
- ❑ At work
- ❑ In bedroom
- ❑ In kitchen
- ❑ In attic
- ❑ In basement
- ❑ Animals
- ❑ Spring
- ❑ Fall
- ❑ Hot weather
- ❑ Weather changes
- ❑ Change of seasons
- ❑ In the morning
- ❑ During the night

ARE YOU FREQUENTLY EXPOSED TO:

- ❑ Indoor pets
- ❑ Plants/flowers
- ❑ Basements
- ❑ Attics
- ❑ Dust
- ❑ Books/papers
- ❑ Stuffed furniture
- ❑ Farms/Crop fields
- ❑ Chemicals
- ❑ Musty/Damp rooms

Do you smoke? ❑ Yes ❑ No

Are you around 2nd hand smoke? ❑ Yes ❑ No

Do you drink alcohol? ❑ Yes ❑ No

If Yes, number of drinks per week? _____________

(OVER)

CHART #:_____________

TYPE OF:

HOME: ❑ Single member ❑ Family ❑ Apt/Condo ❑ Mobile Home Age of home: ___________

HEATING SYSTEM: ❑ Central ❑ Gas ❑ Electric ❑ Other ____________________

FLOOR COVERINGS: ❑ Carpet, # of rooms ___ ❑ Wood ❑ Linoleum ❑ Other _________________

PILLOW: ❑ Foam ❑Feather ❑ Cotton ❑ Encased Age of pillow: ____________

MATTRESS: ❑ Cotton ❑ Feather ❑ Foam ❑ Rubber ❑ Waterbed ❑ Encased Age of mattress:_____________

PETS: *(Indicate animals you are frequently exposed to)*

❑ Dog
❑ Cat
❑ Rabbit
❑ Horse
❑ Bird
❑ Hamster
❑ Other ____________

PREVIOUS ALLERGY TESTING:

Have you ever been tested for allergies? ❑ Yes ❑ No

If Yes: When: ____________________ Method: ❑ Skin Test ❑ Blood Test Where: ____________________

If Yes, Did you follow up with Allergy Shots? ❑ Yes ❑ No

FAMILY HISTORY: *(Indicate **members of your family** who have tested positive for allergies)*

❑ Mother
❑ Father
❑ Sister
❑ Brother
❑ Grandmother
❑ Grandfather

PATIENT MEDICAL HISTORY: *(Check if **you** now have or have ever been diagnosed with)*

❑ Diabetes
❑ HIV/AIDS
❑ Bronchitis
❑ Heart trouble
❑ Chronic lung disease
❑ Thyroid problems
❑ High blood pressure
❑ Asthma
❑ Severe allergic reaction
❑ Stroke
❑ Depression
❑ Psychiatric disorders
❑ Bleeding disorders
❑ Cancer
❑ Sleeping disorders
❑ Kidney or Liver problems
❑ Seizure disorder
❑ Arthritis
❑ Migraines
❑ Other: ___________________
____

***Women:** Are you pregnant, suspect you are pregnant, or think you may become pregnant? ❑ Yes ❑ No

LIST ALL MEDICATIONS WITH DOSAGE AND HOW OFTEN YOU TAKE:

*(Including **over-the-counter** and **herbal** supplements)*

________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________
________________________________ ________________________________

Signature:____________________________________ Date: ______________________________
(Parent or Guardian)

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