Patient History

Please print your answers

Name: _____ Age: _____ Date _____

Referring physician (if any) _____

Asthma □ Yes □ No Age of onset _____

Seasonal □ Yes □ No Which season(s)? _____

Which of the following worsens your asthma? □ Infections □ Exercise □ Laughing □ Cold air □ Smoke
□ Strong odors □ Dampness □ Dust □ Chemicals □ Aspirin

□ Foods (please list)

□ Animals (please list)

□ Drugs (please list)

□ Other (describe)

Time of day you are worst: □ Upon arising □ Late A.M. □ Early P.M. □ No pattern

Nasal Allergy □ Yes □ No Age of onset _____ □ Seasonal Which season(s) _____
or
Sinus Condition □ Yes □ No Age of onset _____ □ Seasonal Which season(s) _____

Frequency of attacks: _____

Symptoms are: □ Runny □ Stuffy/stopped up □Sneezing □ Post-nasal drainage □ Headaches
□ Chronic sinus infections

Do you use nose OTC drops or spray □ Yes □ No If yes, how often? _____

Name of drops or spray _____

Symptoms worsened by: _____

Skin Allergy □ Yes □ No □ Past □ Present

Hives □ Yes □ No □ Past □ Present

Rash/eczema □ Yes □ No □ Past □ Present Describe _____

_____

Approximate date of onset: _____ Frequency of episodes _____

Suspected Causes: _____

PLEASE SEE NEXT PAGE

Insect Sting Allergy □ Yes □ No

Describe symptoms**: _____**

Date of onset: _____ Number of episodes: _____

Which insect? _____

Did any episode require emergency treatment? □ Yes □ No

Food allergy or sensitivity □ Yes □ No (Describe more fully on Food History form – InitialDietForm)

Your Home and work

Do you Smoke? □ Yes □ No Do any immediate family members smoke in your home? □ Yes □ No

Age of residence: _____ Basement? □ Yes □ No Flat roof? □ Yes □ No

Do you feel your home causes you to have any significant symptoms? □ Yes □ No

Air conditioning? □ Yes □ No Swamp cooler? □ Yes □ No Humidifier? □ Yes □ No

Bedroom rugs? □ Yes □ No Rugs made of wool? □ Yes □ No

Type of pillow: □ Feather □ Foam □ Fiberfill

Do you have animals? □ Yes □ No What kind of animals? _____

Are your animals mostly □ Indoors □ Outdoors □ In and Out

Do your animals sleep on your bed? □ Yes □ No

In your room? □ Yes □ No

Family members with allergy? □ Yes □ No

□ Father □ Mother □ Sister □ Brother

□ Grandfather □ Grandmother □ Aunt □ Uncle □ Cousin

□ Children

Occupation: _____

Are you exposed to any major chemicals at work? □ Yes □ No

If so, which ones? _____

Have you had previous allergy skin testing? □ Yes □ No

Have you had allergy shots? □ Yes □ No □ Previously □ Currently

Is there anything else you'd like to discuss?