



Allergy, Asthma & Sinus Center

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Name: _____ Date: _____ Age: _____ Gender: M/F _____

What is your main allergy concern: _____

Symptoms: Please circle those symptoms that bother you in the chart below:

Eyes	Nose	Ears	Sinus	Throat	Skin	Chest	Abdomen	Reactions/Other
Itching	Itching	Itching	Headaches	Itching	Itching	Tightness	Acid Reflux/ Heartburn	Cosmetics/ Jewelry
Watering	Sneezing	Fullness	Sinus Pressure	Postnasal Drip	Hives	Coughing	Trouble Swallowing	Foods
Red	Congestion/ Decreased smell	Popping	Sinus Infections	Hoarseness	Eczema	Wheezing	Pain	Insects/Bees
Swelling	Runny	Infections	Discolored drainage	Throat Clearing	Swelling	Shortness of Breath	Nausea/ Vomiting	Latex
Burning	Mouth Breathing, Snoring/ Sleep apnea	Decreased Hearing	Bad breath	Bad or Decreased Taste	Other Rashes	Exercise Induced Trouble Breathing Or Cough	Diarrhea	Aspirin

How long have you had these symptoms: _____ # Missed days of school/work due to symptoms: _____

These symptoms occur: (circle all that apply) Spring Summer Fall Winter All of the time

These symptoms are worse when/with: (circle all that apply)

Outdoors	Indoors	Morning	Night	All Day	School	Work	Home	Pets (cat, dog, other)
Cold Air	Humid	Rain	Dust	Pollens	Molds	Change in Temperature	Change in Pressure	
Tobacco Smoke	Excercise	Aspirin/Ibuprofen	Food	Odors	Scented candles/perfumes	Other: _____		

Allergies	Yes/No	Healthcare Provider's Notes:
Any previous allergy testing?		
Any previous allergy shots?		
Reactions to shots: local or general?		
If on shots before, provide dates: _____ to _____		
Asthma		
Diagnosis of asthma made: _____ years ago		
# of asthma ER visits: per year _____, per lifetime _____		
# of asthma hospitalizations: in lifetime _____		
Dates for last ER visit: _____ last hospital visit: _____		
Do you use a spacer for your inhaler? Yes or No		
Frequent Infections	# per year	# per life
Ear		
Sinus		
Pneumonia		

Previous Imaging of Sinuses or Chest (X ray or CT scan) Date and Results: _____

Name: _____ Date: _____

Home Environment Survey (circle all that apply)

Lives in Basement	Feather Pillow	Forced Air Heat	Fan/Humidifier	Cats (how many)? _____
Plastic Covered Mattress/Pillow	Stuffed Toys	Windows Closed	Change Filters	Dogs (how many)? _____
Down Bedding	Carpet/Rugs	A/C	Cockroaches	Pets in Bedroom
Other Pets? _____				
Type of window treatment (circle all that apply) Blinds ◦ Curtains ◦ Shades				
Cigarette smoke: Yes or No. # packs you smoke per day _____ # of years you have smoked? _____				
Quit _____ years ago. Passive smoke exposure at home? Yes or No ◦ Regular Exercise: Yes or No Type _____				
Marijuana: Yes or No				

Social History (circle all that apply)

What environment do you currently live in? House ◦ Town House ◦ Apartment ◦ Trailer ◦ Rural ◦ Urban	Daycare: Yes or No Current school grade: _____
Marital Status: (circle) Married ◦ Single ◦ Divorced ◦ Separated ◦ Widowed ◦ Other	Occupation: _____

Past Medical History

Current Medications

All Current Medical Conditions (Including those associated with medication listed)	Name	Dose	Frequency

Past Surgeries or Hospitalizations	Age/Year

Drug Allergy	Reaction

Review of Systems (circle all that apply)

Fatigue	Blurred Vision	Deviated Septum of Nose	Leg Swelling (edema)	Heartburn	Joint Pain
Fever	Cataract	Frequent Sore Throats	High Blood Pressure	Nausea/Vomiting	Anxiety
Dry Skin	Glaucoma	Hoarseness	Irregular Heart Beat	Diarrhea	Behavior Problems
Rashes	Ear Pressure	Metallic Taste	Passing Out	Dizziness	Depression
Dry itchy eyes	Nose Bleeds	Cold/Heat Intolerance	Abdominal Pain	Headache	Other

Family History: Who in your family has these conditions?

Allergies	Hypertension	Hives/Swelling	Cystic Fibrosis	Autoimmune Disease
Sinus Infections	Emphysema/COPD	Thyroid Disease	Eczema	Diabetes
Frequent Infections	Asthma	Heart Disease	Food Allergies	Tuberculosis

Vital Signs (Nurse): WT: _____ HT: _____ T: _____ BP: _____ HR: _____ POX: _____

Physical Exam (Doctor):

HEENT: _____ LUNG: _____

CV: _____ SKIN: _____