Patient Name: _____ **Date:** _____

Address: _____ **Date of Birth:** _____

City, State, Zip: _____ **Phone#:** _____

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

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.*
- *An 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

☐ Infant (Age 0-2) ☐ Child (Age 3-5)

☐ Child (Age 6-12) ☐ Adolescent (Age 13-18)

☐ Adult (Age 19-25) ☐ Adult (Age 26-40)

☐ 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 <u>ONE HOUR TO THREE DAYS</u> AFTER EXPOSURE

- ☐ Eggs
- ☐ Milk
- ☐ Beef
- ☐ Corn
- ☐ Wheat
- ☐ Soybean
- ☐ Peanut
- ☐ Pork
- ☐ Fish
- ☐ Shellfish
- ☐ Orange or other citrus
- ☐ Potato
- ☐ Tomato
- ☐ Yeast
- ☐ Chocolate
- ☐ Coffee or Tea
- ☐ Other _____
- ☐ None

CHEMICALS THAT CAUSE SYMPTOMS

- ☐ Insecticides & pesticides
- ☐ Perfumes & cosmetics
- ☐ Stove or furnace emissions
- ☐ Chemicals in the workplace
- ☐ Newsprint
- ☐ None
- ☐ Paints & household cleaners
- ☐ Gasoline or automobiles exhaust
- ☐ The smell of new fabrics or fabric store
- ☐ Laundry detergent
- ☐ Other: _____

WHEN ARE YOUR SYMPTOMS WORSE

☐ Year around

☐ January ☐ February ☐ March ☐ April

☐ May ☐ June ☐ July ☐ August

☐ September ☐ October ☐ November ☐ 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? _____

_____

_____

_____

_____

_____