ALLERGY and ASTHMA CENTER of AUSTIN

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INSTRUCTIONS: Please answer the questions on this form as they relate to the person being evaluated. Please bring the completed forms to our office for your first appointment.

Patient's Name:____________________ Sex:______ Age:______ Date of Birth:__________

Referred by:____________________ Primary Doctor:____________________ Appointment Date:__________

I. BRIEFLY DESCRIBE the reason for your allergy visit and what you hope to accomplish:____________________

____

____

II. SYMPTOMS: Do you experience any of the following? (Check ✔ each box that applies to you.)

✔	NOSE:	✔	SINUS:	✔	CHEST:	✔	SKIN:
	Stuffy nose		Headaches		Tightness		Rash
	Sneezing		Sore throats		Wheezing		Hives
	Itching		Post nasal drainage		Wheezing when exposed to dust, pollen, animals, etc.		Eczema
	Clear / colorless discharge		Throat clearing / sniffing				Swelling
	Thick / colored discharge		Hoarseness		Wheezing with colds / infections		Itching
	Mouth breathing / snoring		Bad breath		Wheezing/cough after exercise		Sores
	Loss or decreased sense of smell		Frequent infections		Shortness of breath	✔	**OTHER:**
	Nose bleeds	✔	**EAR:**		Productive cough		Fatigue
✔	**EYE:**		Itching		Dry cough		
	Red		Full / popping		Bronchitis		
	Itchy		Painful				
	Watery		Ringing / hearing loss				
	Dark circles / puffiness		Frequent infections				

III. TRIGGERS OF YOUR SYMPTOMS: Are your symptoms ❑ Year Round ❑ Seasonal ❑ Both?

During what months do you usually have symptoms? ❑ January ❑ February ❑ March ❑ April ❑ May ❑ June ❑ July ❑ August ❑ September ❑ October ❑ November ❑ December

Which of the following cause your symptoms or make them worse? (Check ✔ each box that applies to you.)

	Mowing lawn / yard work		Weather change		Perfume		Morning
	Vacuuming / house dust		Wet weather		Chemical fumes		Afternoon
	Cedar		Dry weather		Smoke		Night
	Pollen		Windy day		Cleaning agents		Alcohol
	Mold or mildew		Hot day		Newspaper		Beer
	Damp areas		Cold day		Indoors		Wine
	Dogs		Air-conditioning		Outdoors		Stress
	Cats		Air pollution		At home		Other
	Other animals				At work		

✍ ✍ ✍ **DO NOT WRITE BELOW THIS LINE** ✍ ✍ ✍

Clinical Summary:____

____

IV. DURATION / SEVERITY OF SYMPTOMS:

Have your symptoms been present: ❑ all of your life? ❑ _______month / years? Are your symptoms:

	Mild		Rare		Interfering with your life
	Moderate		Frequent		Preventing many normal activities
	Severe		Constant		

V. FOOD REACTIONS:

Have you ever had any ***systemic symptoms*** (itching, hives, wheezing, shortness of breath, throat swelling, dizziness, fainting, shock) after ingestion of food or liquid? ❑ YES ❑ NO If yes, specify:

____

____

Do you have significant ***intestinal symptoms*** (nausea, vomiting, cramps, pain, diarrhea) after ingestion of food or liquid? ❑ YES ❑ NO If yes, specify:____

____

____

VI. INSECT STING REACTIONS:

Have you ever had ***systemic symptoms*** (hives, wheezing, shortness of breath, dizziness, fainting) after an insect sting? ❑ YES ❑ NO If yes, specify:

____

____

VII. MEDICATIONS:

▼ Please list **ALL PRESENT MEDICATIONS** below. ▼			▼ List **PREVIOUS ALLERGY** and/or **ASTHMA** medications below. ▼
Drug	Dose	Date Started	Drug
1.			1.
2.			2.
3.			3.
4.			4.
5.			5.
6.			6.
7.			7.
8.			8.

Have you used nasal sprays? ❑ YES ❑ NO If yes, name:______________________________

Have you taken cortisone (steroids)? ❑ YES ❑ NO If yes, when:______________________________

VIII. MEDICATION REACTIONS:

List any medication **allergy or reaction** below.

Medication	Approximate Date	Symptoms

Have you ever had a reaction to x-ray dye? ❑ YES ❑ NO If yes, specify:______________________________

IX. PREVIOUS ALLERGY EVALUATION:

Have you seen an allergist? ❑ YES ❑ NO If yes, allergist's name:______________________________

Have you had allergy skin testing? ❑ YES ❑ NO If yes, date?_________Any positive reactions? ❑ YES ❑ NO

Have you received allergy injections? ❑ YES ❑ NO If yes, dates:______________________________

Did your symptoms improve while you received injections? ❑ YES ❑ NO

Have you ever experienced an adverse reaction to an allergy injection? ❑ YES ❑ NO If yes, please specify:

____

X. HOME ENVIRONMENT:

Do you live in a: ❑ House ❑ Apartment ❑ Condominium ❑ Mobile Home ❑ Single ❑ Two story

How long have you lived there?______years/months Age of home:______years

Is it located on / near: ❑ Water ❑ Vacant land ❑ Industrial area ❑ Farm

Air conditioning: ❑ Central ❑ Window ❑ None Ceiling fans: ❑ YES ❑ NO

Type of flooring: ❑ Carpet ❑ Wood ❑ Tile ❑ Vinyl ❑ Other
❑ Throughout ❑ In bedrooms ❑ Living room

How old is your mattress?________Type of mattress: ❑ Inner spring ❑ Water ❑ Allergy encasing

How old is your pillow?__________Type of pillow: ❑ Feather ❑ Synthetic ❑ Foam ❑ Allergy encasing

Do you have any pets? ❑ YES ❑ NO If yes, list the number and kind (i.e. dog, cat, bird, etc.)

____

Are your allergy / asthma symptoms worse around your pets? ❑ YES ❑ NO

Do your pets live: ❑ Indoors ❑ Outdoors ❑ Both?

Do your pets sleep in your bedroom? ❑ YES ❑ NO Do your pets sleep on your bed? ❑ YES ❑ NO

XI. WORK ENVIRONMENT:

What is your occupation?________________________Where are you employed?________________________

How long have you worked there?__________________Is your work environment: ❑ Carpeted ❑ Tiled ❑ Other

Is it air conditioned? ❑ YES ❑ NO Is smoking permitted? ❑ YES ❑ NO

Are you exposed to chemicals or strong odors? ❑ YES ❑ NO

If yes, please specify:____

Are your symptoms worse at work? ❑ YES ❑ NO If yes, please specify:______________________

Have you missed time from work because of allergies? ❑ YES ❑ NO If yes, how much time?________________

Comments:____

XII. SCHOOL HISTORY / ENVIRONMENT:

Do you attend school? ❑ YES ❑ NO If yes, what grade level?________________________

Is your classroom: ❑ Carpeted ❑ Tiled ❑ Other Any animals in your classroom? ❑ YES ❑ NO

Do you participate in physical education? ❑ YES ❑ NO

Have you missed time from school because of allergies / asthma? ❑ YES ❑ NO

If yes, how many days missed last year?_____________Comments:______________________________

XIII. PAST MEDICAL HISTORY:

▼ Please list any surgeries / hospitalizations / medical conditions below.▼	Date

Childbirth? ❑ YES ❑ NO If yes, list date / dates:______________________________________

____

XIV. SYSTEMS REVIEW: Do you have recurrent or chronic problems with any of the following?

❑ Frequent headaches
❑ Vision disturbance
❑ Wear glasses
❑ Wear contacts / soft / gas perm
❑ Frequent colds,_____per year
❑ Chest pain
❑ Pneumonia
❑ High blood pressure
❑ Rapid heart beat
❑ Nausea / vomiting
❑ Heartburn
❑ Constipation
❑ Diarrhea
❑ Frequent / painful urination
❑ Arthritis

Any other chronic symptoms?________________________________

What is your weight now?____________ What was your weight one year ago?____________
When was your last chest x-ray?____________ Results:____________
Have you had sinus x-rays? ❑ YES ❑ NO If yes, results:____________

XV. SOCIAL:

Where were you born?____________ Raised?____________
Where have you lived?________________________________

When did you move to Central Texas?__________ Are you: ❑ Married ❑ Single ❑ Widowed ❑ Divorced
What was the last grade of school you completed?____________
How many children do you have?__________ Their ages:____________
Do you exercise? ❑ YES ❑ NO If yes, how often?____________ How long?____________
Do you drink alcohol? ❑ YES ❑ NO If yes, how often?____________ How much?____________

XVI. SMOKING:

Do you presently smoke? ❑ YES ❑ NO If yes, average number of cigarettes per day:____________
If yes, when did you start?____________
Have you ever smoked? ❑ YES ❑ NO If yes, how many years?__________ When did you stop?__________
Average number of cigarettes you smoked per day?____________
Does anyone smoke in your home? ❑ YES ❑ NO If yes, who?____________

XVII. FAMILY HISTORY:

List family members who have a history of any of the following illnesses:
(Check ✔ each box which applies to a family member.)

	Hay fever		Headaches
	Asthma		Cancer
	Eczema		Diabetes
	Hives		High blood pressure
	Swelling		Heart attack
	Food allergy		Other

IF PATIENT IS A CHILD, PLEASE COMPLETE THE FOLLOWING:

Place of birth?____________ Age of mother at birth?____________
Was pregnancy / labor / delivery normal? ❑ YES ❑ NO
If no, please specify:____________
Birth weight?____________ ❑ Formula or ❑ Breast-fed Well tolerated? ❑ YES ❑ NO
Has child reached normal growth milestones? ❑ YES ❑ NO
If no, please specify:____________
Your relationship to child:____________