# 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 | | Eczema |
| | Clear / colorless discharge | | Throat clearing / sniffing | | dust, pollen, animals, etc. | | 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:**_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

**ALLERGY and ASTHMA CENTER of AUSTIN** **PATIENT NAME:**

## 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:

_____

**ALLERGY and ASTHMA CENTER of AUSTIN** **PATIENT NAME:**

## 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:_____