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**Patient Information**

Patient Name		Today's Date	
Occupation	Age	Sex	Date of birth
If child, Mother's Name & Occupation		Father's Name & Occupation	
Address: Street	City, State		Zip
Home phone	Work	Cell	
Insurance carrier		Referring Physician	

What problem brings you or your child to this appointment? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

When did symptoms begin? \_\_\_\_\_ Are your symptoms getting worse?  Yes  No

Do you have any of these symptoms? (Check all that apply)

- Cough
- Wheezing
- Shortness of breath
- Chest tightness
- Sneezing
- Phlegm /Sputum (color) \_\_\_\_\_
- Runny Nose
- Nasal Congestion
- Itchy Nose
- Itchy / Watery Eyes
- Postnasal Drip
- Nasal Polyps
- Poor Sense of Smell
- Ear Infections
- Sinus Infections
- Blocked Ears
- Other \_\_\_\_\_
- Eczema
- Hives/Swelling
- Headaches
- Snoring
- Pneumonia

Check any of the following which seem to trigger (or cause) symptoms or bother you:

- Grass
- Hay
- Mold & Mildew
- Basements
- Leaves
- Jewelry
- Cats
- Dogs
- Horses
- Other animals
- Odors
- Other \_\_\_\_\_
- Cosmetics
- Aerosol sprays
- Perfumes
- Insecticides
- Exercise
- Drafts
- House dust
- Smoke
- Pollution
- Latex
- Nervousness
- Cold Air
- Humidity
- Weather changes
- Alcoholic beverages

When are your symptoms worse?  Year Round  
 Jan  Feb  Mar  Apr  May  Jun  Jul  Aug  Sept  Oct  Nov  Dec

Are symptoms better away from home?  Yes  No If Yes, when? \_\_\_\_\_

Have you been skin tested?  Yes  No Results: \_\_\_\_\_

Have you had allergy injections?  Yes  No When: \_\_\_\_\_

Have you received cortisone (prednisone) drugs?  Yes  No When \_\_\_\_\_ How much: \_\_\_\_\_

**YOUR PAST MEDICAL HISTORY:**

List any hospitalizations/surgeries:

Other medical problems:

- Diabetes
- Heartburn/reflux
- Depression/anxiety
- High blood pressure
- Thyroid disease
- Autoimmune disease
- Heart disease
- Cancer
- COPD
- Ear/nose/sinus surgery
- Yes  No

Were your tonsils/adenoids removed?  Yes  No

**CURRENT MEDICATIONS** (include non-allergy meds, vitamins and alternative/herbal products):

Drug Name                      Dose                      How often taken                      Taken for what condition

**ALLERGIES**

Medication allergies:  None                      If yes, describe what happened: \_\_\_\_\_

Food allergies or intolerances:  None                      If yes, describe what happened: \_\_\_\_\_

Bee sting allergies:  None                      If yes, describe what happened: \_\_\_\_\_

**FAMILY HISTORY**

Who in your family has had: (**NOT** including yourself)

	Father	Mother	Brother(s)	Sister(s)	Son(s)	Daughter(s)	Others
Asthma							
Eczema							
Nasal allergies							
Drug allergy							
Food allergy							
Bee sting allergy							
Sinus problems							
Hives/swelling							
Autoimmune disease							
Thyroid disease							
Recurrent infections							
Tonsil enlargement							
Sleep apnea							

**ENVIRONMENTAL SURVEY**

Do you live in a  House  Apt/Duplex  Condo/Townhouse How long have you lived there? \_\_\_\_\_

Do you have:  Humidifier  Dehumidifier  Air cleaner  HEPA  Ionic breeze

Heating system:  Wood /Coal Stove  Radiators/Forced hot water  Forced hot air  Electric  Mixed

Pets (number) \_\_\_\_\_  Indoor  Outdoor  Cats \_\_\_\_\_  Dogs \_\_\_\_\_  Birds \_\_\_\_\_  Other \_\_\_\_\_

Do you have allergy proof encasing for pillow or mattress  Yes  No

What type of floor covering is in your bedroom?  Wall to wall  Area Rug  Wood

Do you have air conditioning?  No  Window Unit  Central

Is your home/apt humid?  Yes  No

Water leaks, mold contamination?  Yes  No

Do you have problems with roaches or mice?  Yes  No

Do you smoke?  Yes  No How much? \_\_\_\_\_

Have you smoked in the past?  Yes  No When stopped? \_\_\_\_\_ Number of years smoked? \_\_\_\_\_

Any tobacco smokers in your home?  Yes  No

Do you experience any of the following (check all that apply):

General	Yes	No
Recurrent fevers		
Fatigue		
Weight loss/gain		
Eyes		
Blurred vision		
Light flashes		
Pain		
Ear/Nose/Throat		
Hearing difficulty		
Nose bleeds		
Ear pain/popping		
Tooth/tongue problems		
Hoarseness		
Heart		
Fluttering heart		
Unusual heartbeat		
Chest pain		
Swollen ankles		
High blood pressure		
Lungs		
Cough		
Wheeze		
Shortness of breath		
Poor exercise tolerance		

Gastrointestinal	Yes	No
Indigestion/heartburn		
Stomach pains		
Diarrhea		
Vomiting		
Genitourinary		
Pain/burning with urinating		
Up at night to urinate		
Kidney stones		
Problem with periods		
Endocrine		
Excessive sweat		
Constant thirst		
Feel too warm/too cold		
Bone/Joints		
Painful joints		
Swollen joints		
Muscle pain/tenderness		
Skin		
Rashes		
Easy bruising		
Hair loss		
Psychological		
Depression		
Anxiety		

Questionnaire reviewed by: \_\_\_\_\_

For Physician Use

**PHYSICAL EXAMINATION** (circle if positive, cross through if negative)

Temp: \_\_\_\_\_ Pulse: \_\_\_\_\_ BP: \_\_\_\_\_ / \_\_\_\_\_ Resp: \_\_\_\_\_ Height \_\_\_\_\_ Weight: \_\_\_\_\_  
 Head/Face: Sinus tenderness, Flushing  
 Eyes: Conjunctiva (injection, erythema), Eyelids (erythema, edema), shiners  
 OTOSCOPIC: Nasal turbinate edema, erosion, polyps, exudates (watery, purulent, \_\_\_\_\_)  
 NASAL MUCOSA/SEPTUM: Pale, hyperemia, deviation (L, R)  
 OROPHARYNX: Exudate, erythema, oral thrush EARS: TM intact/erythematous  
 TEETH AND GUMS: Bleeding, swelling, others: \_\_\_\_\_ Lymphatic: Neck, Axilla, Groin, others:  
 Neck: Supple, JVD, others: \_\_\_\_\_ Thyroid: Enlargement, Nodules, others:  
 Respiratory: Accessory muscle use, wheezing, rales, rhonchi, clear to auscultation, others:  
 Cardiovascular: Regular rate and rhythm, S1, S2, heart murmur, peripheral edema, JVD, others:  
 Gastrointestinal: Abdomen soft, liver and spleen not palpable, others:  
 Skin: Erythema, Lichenification, Excoriation, Dispigmentation, Urticaria, Angioedema  
 Musculoskeletal: Joint swelling, limitation of movement, others:  
 Psychiatric: Oriented x3, Mood and affect normal, alert Neurological: Normal reflexes

**TESTS ORDERED OR REVIEWED**

Skin tests: 6-panel env, adult food, pedi env, pedi food, eczema panel, other: \_\_\_\_\_  
 PFT: Pre Pre/Post  
 LAB: CBC with eos, CMP, ESR, CRP, TSH, Thyroid Ab, Tryptase RADIOLOGY: CT Sinus, CXR  
 RAST: NE Panel, Nuts, Seafood, Other: \_\_\_\_\_ IgG, A, M, E; Pneumococcal Ab (14)

**DIAGNOSIS**

Extrinsic asthma 493.00	Seasonal allergic rhinitis 477.0	Acute urticaria 708.9
Intrinsic asthma 493.10	Perennial allergic rhinitis 477.8	Chronic urticaria 708.8
Exercise-induced asthma 493.81	Nonallergic rhinitis 477.9	Pruritus 698.9
Cough 786.2	Allergic conjunctivitis 372.14	Angioedema 995.1
Dyspnea 786.05	Acute sinusitis 461.9	Anaphylaxis 995.0
Wheezing 786.07	Chronic sinusitis 473.9	Bee sting allergy 989.5
Reactive Airway Dz 493.90	Food allergy 693.1	_____
Nasal Polyps	Atopic dermatitis 691.8	_____
	Contact dermatitis 692.9	_____

**IMPRESSION**

**PLAN**

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**EDUCATION:**

DM control	Pet avoidance	Nasal spray	Immunotherapy	MDI w/spacer	EpiPen
Mold control	Food avoidance	FAAN	Oral allergy	Peak flow meter	

Physician: \_\_\_\_\_ Date: \_\_\_\_\_

Return to Office: \_\_\_\_\_ days/weeks/months/year for \_\_\_\_\_ follow-up/skin test/intradermal/patch