

**NAME:** \_\_\_\_\_  
**ACCOUNT NO.:** \_\_\_\_\_  
**ADDRESS:** \_\_\_\_\_

**DATE:** \_\_\_\_\_  
**AGE:** \_\_\_\_\_  
**BIRTH DATE:** \_\_\_\_\_

Chief Complaint (Reason for coming in):

Check where applicable:

**Nose/Ears/Eyes/Throat Symptoms**

- First noticed: \_\_\_\_\_
- Sneezing
  - Runny Nose
  - Nasal Congestion
  - Nose Bleeding
  - Loss of Smell
  - Nasal Polyps
  - Post Nasal Drainage
  - Frequent Sore Throat
  - Cough
  - Frequent Respiratory Infections
  - Earaches
  - Ear Infections
  - Hearing Loss
  - Vertigo (Dizziness)
  - Itchy, Watery Eyes

Worst Season: \_\_\_\_\_

**Skin/Eczema**

- Rash
  - Red
  - Swollen (raised)
  - Blisters (fluid filled)
  - Itchy
  - Scaly, dry
  - Infection

Location on Body: \_\_\_\_\_

Any Known Cause(s): \_\_\_\_\_

**Headache Symptoms**

- First noticed: \_\_\_\_\_
- Sharp  Pressure
  - Dull  Vise-like
  - \_\_\_\_\_
- Location: \_\_\_\_\_
- Frequency: \_\_\_\_\_
- Time Headaches Worse: \_\_\_\_\_
- Any Known Cause(s): \_\_\_\_\_

Treatment(s) Tried: \_\_\_\_\_

Associated Symptoms such as

Sinusitis: \_\_\_\_\_

**Hives and/or Swelling**

- Hives; Location: \_\_\_\_\_
  - Swelling; Location: \_\_\_\_\_
- First Noticed: \_\_\_\_\_

Duration: \_\_\_\_\_

Associated Symptoms: \_\_\_\_\_

**Chest Symptoms**

- First noticed: \_\_\_\_\_
- Cough
  - Sputum Color: \_\_\_\_\_
  - Wheeze
  - Tight Chest
  - Attacks
    - Night  Daytime  Work
- Frequency of attacks: \_\_\_\_\_

Last Attack \_\_\_\_\_

Bronchitis

Worst Season: \_\_\_\_\_

**Insect Allergy**

When stung or bitten \_\_\_\_\_

Insect \_\_\_\_\_

Reaction(s): \_\_\_\_\_

Treatment: \_\_\_\_\_

**Latex Allergy**

- Occupation related
- Contact Dermatitis
- Hives
- Wheeze
- Other: \_\_\_\_\_

**Precipitating Factors:** (Check if symptoms are worsened or affected by)

- Weather change
- Rainy days
- Foggy days
- Fumes  
(Insecticides, chemicals, tobacco smoke)
- Physical exertion
- Musty odors

- Perfume or cosmetics
- House cleaning, moving
- House dust
- Mowing the lawn
- Infection
- Change of locale
- Newsprint

- Change in temperature
- Being around animals
- What type? \_\_\_\_\_
- Playing (sitting) on grass
- Emotional stress (worries, excitement, etc.)
- Other: \_\_\_\_\_

**Medications**

Allergy Medications (List all past and current medication given for allergy and state which ones are helpful)

List Other Current (non-allergy medications)

**REVIEW of SYSTEMS**

Please check all items that apply and explain briefly

**General Health:**  Good  Bad \_\_\_\_\_

**Constitutional:** (General Symptoms)  Fever  Weight Loss  Weight Gain  Night Sweats  
 Weakness  Fatigue  None  Other: \_\_\_\_\_

**Eyes:**  Poor Vision  Cataracts  Glaucoma  Glasses  Contacts (Type: \_\_\_\_\_)  
 None  Other: \_\_\_\_\_

**Ear, Nose, Throat and Mouth:** (Not noted in allergy history)  
 Pain  Drainage  Hearing Loss  Vertigo (dizziness)  or Tinnitus (ringing)  Sore Mouth  
 Dental problem  None (other than allergy)  Other: \_\_\_\_\_

**Cardiovascular:** (Heart and blood vessels)  
 High Blood Pressure  Heart Attack  Palpitations (and other arrhythmias)  Heart Murmur  
 Phlebitis  None  Other: \_\_\_\_\_

**Respiratory:** (Covered in Allergy Section)

**Gastrointestinal:**  Peptic Ulcer  Reflux  Hepatitis  Frequent Vomiting  Abdominal Pain  
 Frequent Diarrhea  Loss of Appetite  Chronic Constipation  Bleeding  None  
 Other: \_\_\_\_\_

**Genitourinary:**  Frequent Urination  Dysuria (pain)  Hematuria  Nocturia (frequent night time urination)  
 Recurrent Infection  Sexual Dysfunction  Kidney Stones  Menstrual Problems  Prostate Problems  
 None  Other: \_\_\_\_\_

**Muscularskeletal:**  Joint Pain  Muscle Pain  Weakness  None  Other: \_\_\_\_\_

**Skin:** (Covered in Allergy Section)

**Neurological:**  Fainting  Seizures  Paralysis  Headaches (other than sinus)  
 None  Other: \_\_\_\_\_

**Psychiatric:**  Depression  Anxiety  Insomnia  Abnormal Fears  Mental Breakdown  
 None  Other: \_\_\_\_\_

**Endocrine:**  Thyroid Dysfunction  Diabetes  Adrenal Dysfunction  None  Other: \_\_\_\_\_

**Hematologic/Lymphatic:**  Anemia  Bleeding Problems  Bloodborne infection: Hepatitis B/HIV  
 None  Other: \_\_\_\_\_

**Cancer:**  Type: \_\_\_\_\_  None

**Allergy/Immunology:** (See Allergy other section)  Immunodeficiency \_\_\_\_\_



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**Allergy History:**

Previous allergy tests:  Yes  No If so, when? \_\_\_\_\_ By Whom? \_\_\_\_\_  
 Where Allergy injections started? \_\_\_\_\_ How long were you on them? \_\_\_\_\_  
 Did they help you? \_\_\_\_\_

Medication allergy or intolerance (name drug and briefly describe reactions)

Food allergy (name food and briefly describe reactions)

Contact allergy (poison ivy, cosmetics, leather, metal, etc)

**Environmental History:**

List other places where you lived: \_\_\_\_\_  
 How long have you lived in your present home? \_\_\_\_\_  
 Location (city, farm, etc) \_\_\_\_\_  
 Type of heater/air conditioner \_\_\_\_\_  
 Pets: Indoor \_\_\_\_\_ How long have you had it? \_\_\_\_\_  
       Outdoor \_\_\_\_\_ How long have you had it? \_\_\_\_\_  
 Pillow Type \_\_\_\_\_ With or Without Plastic Cover: \_\_\_\_\_  
 Mattress Type \_\_\_\_\_ With or Without Plastic Cover: \_\_\_\_\_  
 Blanket Type \_\_\_\_\_ How Old is it? \_\_\_\_\_  
 Carpet Type \_\_\_\_\_ Rug Type: \_\_\_\_\_  
 Draperies Type: \_\_\_\_\_ Indoor Plants? \_\_\_\_\_  
 Smoker(s)  Yes  No  In Home  Work Stuffed toys in bedroom? \_\_\_\_\_

**Occupational Habits and Hobbies:**

What type of Work? \_\_\_\_\_  
 Do you smoke? \_\_\_\_\_ How Long? \_\_\_\_\_ How many a day? \_\_\_\_\_  
 Did you smoke in the past? \_\_\_\_\_ How Long? \_\_\_\_\_ When did you stop? \_\_\_\_\_  
 Do you drink alcohol? \_\_\_\_\_ How Often? \_\_\_\_\_  
 Do you use non-medicinal (recreation) drugs? \_\_\_\_\_

**Past Medical History:** (List previous illnesses and hospitalizations; surgeries and Emergency Room visits)

**Family History:**

(Please check if present)

<u>Illness</u>	<u>Father</u>	<u>Mother</u>	<u>Brother</u>	<u>Sister</u>	<u>Children</u>	<u>Other</u>
Asthma	_____	_____	_____	_____	_____	_____
Hay Fever	_____	_____	_____	_____	_____	_____
Sinus Problems	_____	_____	_____	_____	_____	_____
Hives or Swelling	_____	_____	_____	_____	_____	_____
Eczema	_____	_____	_____	_____	_____	_____
Drug Allergy	_____	_____	_____	_____	_____	_____
Sinus Headaches	_____	_____	_____	_____	_____	_____
Migraine Headaches	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Rheumatic/autoimmune	_____	_____	_____	_____	_____	_____
Cancer	_____	_____	_____	_____	_____	_____
Immunodeficiency	_____	_____	_____	_____	_____	_____

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**Additional History:**

1-5	PF
6-11	EPF
12	D
ALL	COMP

**Physical Examination:** (0= negative or normal; X= abnormal or present; NE=not examined)

BP: \_\_\_\_\_ P: \_\_\_\_\_ Resp: \_\_\_\_\_ Temp: \_\_\_\_\_ Ht: \_\_\_\_\_ Wt: \_\_\_\_\_

General Appearance: \_\_\_\_\_

Allergic Facies \_\_\_\_\_ Allergic Shiners \_\_\_\_\_ Horizontal Nasal Crease \_\_\_\_\_ Allergic Salute \_\_\_\_\_

Eyes: Conjunctiva: \_\_\_\_\_

Nose: Mucosa: \_\_\_\_\_ Mucus \_\_\_\_\_  
 Ederna: \_\_\_\_\_ Polyps \_\_\_\_\_  
 Septum: \_\_\_\_\_ Turbinates: \_\_\_\_\_

Oral Cavity: \_\_\_\_\_ Pharynx \_\_\_\_\_  
 Teeth & Gums \_\_\_\_\_ PN Drip: \_\_\_\_\_

Ears: TM's: \_\_\_\_\_ Canals: \_\_\_\_\_  
 TMJ \_\_\_\_\_ Face/Sinus Tenderness \_\_\_\_\_

Neck: \_\_\_\_\_ Thyroid (Enl/Tend/Mass) \_\_\_\_\_

Lymphatics: Neck: \_\_\_\_\_ Axilla \_\_\_\_\_ Groin \_\_\_\_\_

CVS: Heart (Snd/M) \_\_\_\_\_ PV (Observ/palp) \_\_\_\_\_

Abdomen: Mass: \_\_\_\_\_ Tenderness: \_\_\_\_\_ Liver: \_\_\_\_\_ Spleen: \_\_\_\_\_

Chest: Ventilation: \_\_\_\_\_ ABN Sounds: \_\_\_\_\_  
 Wheezing: \_\_\_\_\_  
 Rales: \_\_\_\_\_ Rhonchi: \_\_\_\_\_  
 Resp. Effort (Retr/Accumuse/Diaph) \_\_\_\_\_

Skin: Rash: \_\_\_\_\_ Lesion: \_\_\_\_\_ Other: \_\_\_\_\_  
 Eczema: \_\_\_\_\_ Flexural: \_\_\_\_\_ Other: \_\_\_\_\_

Extremities: Inspection \_\_\_\_\_ Palpation: \_\_\_\_\_

Neuro/Psych: Orientation: \_\_\_\_\_ Mood & Effect: \_\_\_\_\_

**Description of Abnormal Findings:**

**Impression:**

**Orders:**