



**III. TRIGGERS OF YOUR SYMPTOMS:** Are your symptoms  Year round,  Seasonal,  Both?

For each item below - check the box to indicate if your symptoms are worse when exposed to:

Changes in Season	Animal Dander - Cat	Exercise
Changes in Weather	- Dog	With Infections
Changes in Humidity	Cigarette Smoke	Emotional Stress
House Dust	Perfumes	
Blowing Dust	Newsprint	
Cut Grass	Chemical Odors	
Mold or Mildew		
Pollen		

**IV. FOOD REACTIONS:** Have you ever had any symptoms (rash, hay fever, vomiting, gas, cramps, diarrhea, colic as an infant) after ingestion of any food or liquid? (If yes, specify below.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**V. INSECT STING REACTIONS:** Have you ever had any systemic symptoms (hives, wheezing, shortness of breath, dizziness, fainting) after an insect sting? (If yes, specify below.) \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**VI. MEDICATION REACTIONS:**

Medication	Approx. Date	Symptoms

Have you ever had a reaction to x-ray dye? \_\_\_\_\_ Please specify: \_\_\_\_\_

Have you ever had a reaction to rubber products? \_\_\_\_\_ Please specify: \_\_\_\_\_  
ie: balloon, rubber ball, glove

**VII. PREVIOUS ALLERGY EVALUATION & TREATMENT:**

Have you ever had allergy skin testing?  Yes  No Were there any positive reactions?  Yes  No

If yes, date: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

If yes, date: \_\_\_\_\_ Physician's Name: \_\_\_\_\_

Have you ever received allergy injections?  Yes  No

If yes, dates: \_\_\_\_\_

Did your symptoms improve while you received injections?  Yes  No

Did you ever experience an adverse reaction to an allergy injection?  Yes  No

If yes, please specify: \_\_\_\_\_

**VIII. ENVIRONMENT:**

Do you live in a/an: House \_\_\_\_\_ Apt. \_\_\_\_\_ Condo \_\_\_\_\_ Mobile Home \_\_\_\_\_ Duplex \_\_\_\_\_

Is it located on/near: The water \_\_\_\_\_ Vacant land \_\_\_\_\_ Industrial area \_\_\_\_\_ Canal \_\_\_\_\_

Age of house: \_\_\_\_\_ years Single or Two-story \_\_\_\_\_ Is there mildew present? \_\_\_\_\_

How long have you lived there: \_\_\_\_\_ years/months.

Type of Air Conditioning: (central, window, etc.) \_\_\_\_\_

Type of flooring: (carpet, wood, tile, vinyl, etc.) \_\_\_\_\_ Is it: throughout \_\_\_\_\_ in bedrooms \_\_\_\_\_ in living room \_\_\_\_\_

How old is your mattress? \_\_\_\_\_

Is your mattress: foam \_\_\_\_\_ innerspring \_\_\_\_\_ encased in plastic \_\_\_\_\_ cotton \_\_\_\_\_ water bed \_\_\_\_\_ other \_\_\_\_\_

How old is your pillow? \_\_\_\_\_ Is your pillow: feather \_\_\_\_\_ synthetic (dacron) \_\_\_\_\_ foam \_\_\_\_\_ other \_\_\_\_\_

Do you have any pets? \_\_\_\_\_ List number and kind (i.e. dog, cat, bird, etc.) \_\_\_\_\_

Do the pets sleep in your bedroom? \_\_\_\_\_

Are there smokers present in the home? \_\_\_\_\_

**IX. WORK HISTORY/ENVIRONMENT:**

What is your occupation? \_\_\_\_\_  
 Where are you employed? \_\_\_\_\_  
 How long have you worked there? \_\_\_\_\_  
 Is your work environment: carpeted \_\_\_\_\_ tiled \_\_\_\_\_  
 Is it air conditioned? \_\_\_\_\_ Is smoking permitted? \_\_\_\_\_  
 Are you exposed to chemicals or strong odors? \_\_\_\_\_  
 If yes, please specify: \_\_\_\_\_  
 Are your symptoms worse at work?  Yes  No If yes, please specify \_\_\_\_\_  
 Have you missed any time from work or because of your allergies? \_\_\_\_\_ How much time? \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**X. SCHOOL HISTORY/ENVIRONMENT:**

What school do you attend? \_\_\_\_\_  
 What grade/level? \_\_\_\_\_  
 Is your classroom: carpeted \_\_\_\_\_ tiled \_\_\_\_\_ Is there a problem with mildew? \_\_\_\_\_  
 Do you participate in physical education? \_\_\_\_\_  
 Have you missed any time from school because of your allergies? \_\_\_\_\_ How many days missed last year? \_\_\_\_\_  
 Do you feel school performance has been affected by allergies? \_\_\_\_\_  
 Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**XI. MEDICATIONS:** Please list all medications below.

Drug	Dose	Date Started	Drug	Dose	Date Started

**XII. PAST MEDICAL HISTORY:** Please list any Surgeries/Hospitalizations/Medical Conditions.

Hospital or Dr. Treating	Reason (specific surgery or medical condition)	Date

**Childbirth, Dates** \_\_\_\_\_  
**Dental History:** Have you ever worn braces? \_\_\_\_\_ Do you wear dentures? \_\_\_\_\_

**XIII. IMMUNIZATIONS:** Approximate dates:

Polio \_\_\_\_\_ HIB \_\_\_\_\_ Last PPD (Tb test) \_\_\_\_\_  
 DPT \_\_\_\_\_ Measles \_\_\_\_\_ Last Chest X-ray \_\_\_\_\_  
 Tetanus booster \_\_\_\_\_ Rubella \_\_\_\_\_ Other \_\_\_\_\_  
 Pneumovax \_\_\_\_\_ Influenza (flu) \_\_\_\_\_ \_\_\_\_\_

**XIV. SYSTEMS REVIEW:** Have you ever had any of the following? (Check all items.)

- Frequent Headaches
- Hearing Loss
- Frequent Ear Infections
- Vision Disturbance
- Glasses
- Blindness
- Frequent Colds
- Coughing
- Wheezing
- Pneumonia
- High Blood Pressure
- Chest Pain
- Rapid Heart Beat
- Nausea/Vomiting
- Constipation
- Diarrhea
- Frequent Urination
- Painful Urination
- Bedwetting
- Arthritis
- Fatigue

**Females Only:**

Are periods regular?  Yes  No  
 Interval \_\_\_\_\_ Duration \_\_\_\_\_  
 At what age did they begin? \_\_\_\_\_

**Males Only:**

Prostate trouble?  Yes  No  
 Impotence?  Yes  No

What is your weight now? \_\_\_\_\_ What was your weight one year ago? \_\_\_\_\_

Do you have any other chronic symptoms? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**If patient is a child, please complete the following:**

Where born: \_\_\_\_\_

Age of mother at birth: \_\_\_\_\_

Was pregnancy/labor/delivery normal: \_\_\_\_\_ If no, please specify \_\_\_\_\_

Birth weight: \_\_\_\_\_ Child is of what # pregnancy: \_\_\_\_\_

\_\_\_\_\_ Child is of what # delivery: \_\_\_\_\_

Formula or breast-fed: \_\_\_\_\_ Well tolerated: \_\_\_\_\_

Has child reached normal growth milestones? \_\_\_\_\_

If no, specify \_\_\_\_\_

**XV. SOCIAL:**

Where were you born? \_\_\_\_\_ Raised? \_\_\_\_\_

Where have you lived? List with approximate dates:

\_\_\_\_\_  
\_\_\_\_\_

When did you move to Florida? \_\_\_\_\_

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? \_\_\_\_\_ How often: \_\_\_\_\_ How long? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ How often: \_\_\_\_\_ How much? \_\_\_\_\_

**XVI. SMOKING:**

Have you ever smoked? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, how many years? \_\_\_\_\_ When did you stop? \_\_\_\_\_

Average number of cigarettes per day? \_\_\_\_\_

Do you presently smoke? \_\_\_\_\_ Yes \_\_\_\_\_ No

Average number of cigarettes per day? \_\_\_\_\_ When did you start? \_\_\_\_\_

Do any other family members smoke? \_\_\_\_\_ Please list below, \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

**XVII. FAMILY HISTORY:** Do any members of your family have a history of allergy? \_\_\_\_\_

**If yes, list all relatives and their ages:**

<input type="checkbox"/> Asthma	<input type="checkbox"/> Cancer
<input type="checkbox"/> Eczema	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Hypertension
<input type="checkbox"/> Hives	<input type="checkbox"/> Heart Attack
<input type="checkbox"/> Swelling	<input type="checkbox"/> TB
<input type="checkbox"/> Headaches	

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_