

Neetu Talreja, M.D. Charles N. Webb, M.D. Jeremy Waldram, M.D. Brianne Ayers PA-C Board Certified in Pediatric and Adult Allergy, Asthma & Immunology

		QUESTIONNAIRE Age: DOB: Date:
		Age: DOB: Date: Primary Care Provider:
nererrea		
The majo	or pro	blem you wish to discuss today is:
History o	f pres	sent illness:
1. V	Vhat a	allergy problem(s) do you have? (please circle)
Runny/st	uffy n	ose Sinusitis Insect Allergy Eye or ear problems Asthma
		Eczema/Rash Drug Allergy Headache
Cough		
Other		
		$\underline{\textbf{L}}$ prescription and over-the-counter medications you are currently using (Name & Dosage):
		6)
		7)
		8)
		9)
		10)
What me	dicati	ons have you tried for your allergy problems in the past?
Are you a	allergi	c to any medications? If so, list drug, type of reaction and when:
3. S	ympt	oms (please check all that applies)
	a.	Eyes: Itch Swell Burn Tear Discharge Dry
	b.	Ears: Itch Fullness Popping Decreased hearing Pain Ringing
	c.	Nose: Sneeze Itch Runs Stuffy Mouth breather Snoring
		Yellow/Green drainage Decreased smell Decreased taste
	d.	Throat: Itch Sore Post nasal drip Throat clearing Swelling Hoarseness
	e.	Lungs: Cough Phlegm History of Asthma Wheezing Chest tightness
		Shortness of breath with exercise Heartburn
	f.	Head: Headaches? Yes/No Migraines? Yes/No What part of head? How often?
	g.	Skin: Eczema Hives Swelling Rashes Where on the body?
2 0	esnir:	atory Allergies
۷. ۱۰	•	Age of onset of your allergies, and/or asthma
		Do you have daily symptoms?
		Which seasons are your allergies or asthma worse? (circle) Spring/Summer/Fall/Winter/All Year
		Does any particular exposure make you worse? (please check all that applies)
	u.	, , , , , , , , , , , , , , , , , , , ,
		Weather changes, Dampness, Fragrances/Odors, Smoke, Dust, Cosmetics/Aerosols
		Mold, Cats/Dogs/Other animals, Grass/Mowing, Weeds, Trees, Exercise,
		Anger/Stress, Coughing/Laughing, Colds/Respiratory infections, Cold air,
		Foods/Drinks (what?
		Other:

How is it usually treated? f. Have you had nose or sinus surgery? (when?) g. Have you are had ear tubes or a tonsillectomy? (when?) h. Have you been told by a physician that you have nasal polyps? i. Do you have aspirin or NSAID induced nasal symptoms &/or wheezing? If you have Asthma: a. Do you use a spacer device for inhalers? If so, which ones have you used? c. Have you every required steroid pills (prednisone, dosepak) or shots (cortisone) to control your allergie or asthma? If so, how many times? d. Have you ever been hospitalized for your asthma? e. How many times in the past 12 months have you been to the ER with asthma? f. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, Itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you had hives before? So, when and for how long? Previous Allergy Evaluation & Treatment: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Ahonomal Chest x-ray, Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When?				_		How oπen?				
g. Have you been told by a physician that you have nasal polyps? i. Do you have asplin or NSAID induced nasal symptoms &/or wheezing? If you have Asthma: a. Do you use a spacer device for inhalers? b. Have you erequired maintenance inhalers? If so, which ones have you used? c. Have you every required steroid pills (prednisone, dosepak) or shots (cortisone) to control your allergie or asthma? If so, how many times? d. Have you ever been hospitalized for your asthma? e. How many times in the past 12 months have you been to the ER with asthma? f. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Phast Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		How is it usuall	y treated?							
h. Have you been told by a physician that you have nasal polyps? i. Do you have aspirin or NSAID induced nasal symptoms &/or wheezing? If you have Asthma: a. Do you use a spacer device for inhalers? b. Have you required maintenance inhalers? If so, which ones have you used? c. Have you every required steroid pills (prednisone, dosepak) or shots (cortisone) to control your allergie or asthma? If so, how many times? d. Have you ever been hospitalized for your asthma? e. How many times in the past 12 months have you been to the ER with asthma? f. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Postitive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?										
i. Do you have aspirin or NSAID induced nasal symptoms &/or wheezing?		g. mave you ever nad ear tubes or a tonsillectomy? (when?)								
### Assume										
a. Do you use a spacer device for inhalers? Do you use a nebulizer?	1		spiriii or NSAID	illuuceu liasai syilipid	onis a/or wheezing:					
b. Have you required maintenance inhalers? If so, which ones have you used? c. Have you every required steroid pills (prednisone, dosepak) or shots (cortisone) to control your allergie or asthma? If so, how many times? d. Have you ever been hospitalized for your asthma? e. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, litching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results). 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?	,		acer device for	inhalars?	Do you use a nebuliz	or?				
c. Have you every required steroid pills (prednisone, dosepak) or shots (cortisone) to control your allergie or asthma? If so, how many times? d. Have you ever been hospitalized for your asthma? e. How many times in the past 12 months have you been to the ER with asthma? f. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?										
or asthma? If so, how many times? d. Have you ever been hospitalized for your asthma? e. How many times in the past 12 months have you been to the ER with asthma? f. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		b. Have you requi	irea maintenam	ce illiaiers: il 30, will	en ones have you used					
d. Have you ever been hospitalized for your asthma? e. How many times in the past 12 months have you been to the ER with asthma? f. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		c. Have you every	required stero	id pills (prednisone, d	osepak) or shots (cort	isone) to control your allergies				
d. Have you ever been hospitalized for your asthma? e. How many times in the past 12 months have you been to the ER with asthma? f. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		or asthma? If so, ho	ow many times?							
f. How many puffs per week of your quick relief inhaler (albuterol) do you use? g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive Tiles test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results)		d. Have you ever	been hospitaliz	ed for your asthma?_						
g. Do you wake up at night coughing or requiring your inhaler? 3. Insect Allergy a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle)		-		-						
a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Blaebets Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia				-						
a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		g. Do you wake u	p at night cough	ning or requiring your	inhaler?					
a. Have you had a severe allergic reaction to a stinging insect? Yes/No b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?	3.	Insect Allergy								
b. Did it cause a large local reaction? OR cause hives, itching, or swelling all over the body? 4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 4. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?	-		severe allergic	reaction to a stinging	insect? Yes/No					
4. Food Allergy a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?						g all over the body?				
a. Please list all foods and reactions they cause: b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?					, 3,	, <u> </u>				
b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?	4.	Food Allergy								
b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		a. Please list all fo	ods and reaction	ons they cause:						
b. Have you had hives before? (when and for how long?) c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?										
c. Do you have a history or currently suffer from eczema? d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		h Have you had h	ives hefore? (w	hen and for how long						
d. Are you sensitive to latex or rubber products? (explain) Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city: 2. Were you tested for allergies by skin prick test or blood test? If so, when: 3. Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?										
Previous Allergy Evaluation & Treatment: 1. Name of Allergist and city:										
 Name of Allergist and city: Were you tested for allergies by skin prick test or blood test? If so, when: 		,			,					
 Were you tested for allergies by skin prick test or blood test? If so, when: Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other:	Previou	us Allergy Evaluation & ⁻	Treatment:							
 Have you ever received Allergy Shots? If so, when and for how long? Past Medical History: Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: Please list all surgical operations and hospitalizations that you have had: Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) Are you up to date on all recommended vaccinations? 		_								
Past Medical History: 1. Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?										
 Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other:	3.	Have you ever received	Allergy Shots?	If so, when and for he	ow long?					
 Medical Problems: (Please circle) High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other:	Doct M	adical History								
High Blood Pressure Diabetes Thyroid Problem High Cholesterol Heart Disease Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		•	ase circle)							
Abnormal Chest x-ray Sleep Apnea Glaucoma Stomach ulcer Hiatal hernia Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?	Δ.			Thyroid Problem	High Chalesteral	Heart Disease				
Heartburn/Reflux Cancer HIV/AIDS Hepatitis Positive TB test Depression Arthritis Blood Transfusion Kidney disease Prostate Other: 2. Please list all surgical operations and hospitalizations that you have had: 3. Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) 4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?		-		•	_					
Depression Arthritis Blood Transfusion Kidney disease Prostate Other:		•								
Other:		·		<u>-</u>	•					
 Please list all surgical operations and hospitalizations that you have had: Have you had a chest x-ray, sinus x-ray/CT scan, pulmonary function test or blood tests for your allergy or breathing troubles? (comment on results) Are you up to date on all recommended vaccinations? Do you receive yearly flu vaccines? When was last? 		•			Mariey disease	Trostate				
breathing troubles? (comment on results)	2.	Please list all surgical o	perations and h	ospitalizations that yo	ou have had:					
breathing troubles? (comment on results)										
4. Are you up to date on all recommended vaccinations? 5. Do you receive yearly flu vaccines? When was last?	3.									
5. Do you receive yearly flu vaccines? When was last?		breathing troubles? (co	omment on resu	iits)						
5. Do you receive yearly flu vaccines? When was last?	4	Are you up to date on a	all recommende	ed vaccinations?						
	_									

Family History: Please place an "X" in the appropriate box(es) below

	Hay Fever	Asthma	Eczema	Hives	Sinus	Diabetes	Cancer	Hypertension	Menta Illness
Father									
Mother									
Siblings									
Children									
	nv other n	naior medica	l condition(s) that run	s in vour fa	milv:			
10000 1150 0	, 0	najor meanoa	· corrarcion	o, chac i an	3 , 0 aa	······ <i>y</i> ·			
ersonal &	Environm	ental History	/ Circle/Fill	in answer	s according	ly			
1. Tol	oacco smol	ker? No Ye	s Former						
	a. If Yes	or former - I	How much a	nd for hov	v long (Cigs	/packs per da	y and numb	oer of years smok	ed)?
							•	, 	
2. Do	you use re	creational dr	ugs?						
3. Hav	<i>.</i> ve vou drai	nk alcohol in	the last yea	r? No Ye	 S				
	•	often? 1 x M	•			ore x Wk			
						7-9 10 or i	more		
/ \//h		•	•					thom?	
								them?	
					•	•		our carpet?	
								Sleep Number	
7. Wh	nat is your o	occupation?							
Ar	e you expo	sed to any to	oxic chemica	als, noxiou	s substance	s at work?			
8. Ho	w long hav	e you lived ir	n your curre	nt home?_	How	long have yoι	ı lived in th	e Treasure valley	area? _
9. Do	your symp	toms becom	e better wh	ile on vaca	ation or whi	la living come	whore else	1	
40 14/1-						ie livilig sollie	where eise	۲	
IU. Wr	nat are you	r daily activit				_		f	
			ies/hobbies	?					
			ies/hobbies	?				?	
11. Hav	ve you trav	eled outside	ies/hobbies the United	? States in t	he last 6 m	onths?			
11. Hav	ve you trav		ies/hobbies the United any of the fo	?States in toollowing?	he last 6 m	onths?	Where	?	
11. Have view of Seneral	ve you trav Systems: ([eled outside	ies/hobbies the United any of the fo	?States in toollowing? I	he last 6 mo	onths?	Where Mere	?	
11. Hav	ve you trav Systems: ([eled outside	the United any of the fo	?States in toollowing? In the control of the con	he last 6 mo	onths?k)	Where ' Psycho Fea	ogical logical rful, anxious	
11. Have eview of seneral Weight los	ve you trav Systems: (I	eled outside	the United any of the fo	?States in toollowing? In the control of the con	he last 6 mo	onths?k)	Where Psycho Fea exc	?	
11. Have eview of Seneral Weight lose Fevers	ve you trav Systems: ([sss ats	eled outside	ies/hobbies the United any of the fo Neu	?States in toollowing? In the control of the con	he last 6 mo	onths?k)	Where Service Wh	logical rful, anxious essive worry	
11. Have eview of Seneral Weight lose Fevers Night swe	ve you trav Systems: ([ss ats petite	eled outside	ies/hobbies the United any of the fo Neu — End	? States in t ollowing? I irological Weakness/c Tingling/nun	he last 6 mo	onths?k)	Where Service Wh	logical rful, anxious essive worry uble sleeping	
eview of Seneral Weight los Fevers Night swe Loss of ap	ve you trav Systems: ([ss ats petite	eled outside	ies/hobbies the United any of the fo Neu — End	?	he last 6 mo	onths?k)	Where Service Wh	logical rful, anxious essive worry uble sleeping	
eview of seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring	ve you trav Systems: ([ss ats petite	eled outside	ies/hobbies the United any of the fo Neu — — End —	?	he last 6 mo	onths?k)	Psycho Psycho Fea exc Tro Dep Kidney Tro	logical rful, anxious essive worry uble sleeping oression uble starting urine	
eview of Seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly	ve you trav Systems: (I ss ats petite n	eled outside	ies/hobbies the United any of the fo	?	he last 6 mo	onths?k)	Psycho Fea exc Tro Dep Kidney Los	logical rful, anxious essive worry uble sleeping pression uble starting urine s of urine with cough	/sneeze
eview of Seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly	ve you trav Systems: (I ss ats petite n	eled outside	ies/hobbies the United any of the fo	?	he last 6 mo	onths?k)	Psycho Fea exc Tro Dep Kidney Los	logical rful, anxious essive worry uble sleeping oression uble starting urine	/sneeze
eview of Seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly yes & Ears Dry eyes	Systems: (I sss ats petite n	eled outside	ies/hobbies the United any of the form End Gas	?	he last 6 mo	onths?k)	Psycho Psycho Fea exc Tro Dep Kidney Los Free	logical rful, anxious essive worry uble sleeping pression uble starting urine s of urine with cough	/sneeze
eview of seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly yes & Ears Dry eyes Change in	Systems: (I sss ats petite n mph nodes	eled outside	ies/hobbies the United any of the fo	?	he last 6 mo	onths?k)	Psycho Psycho Fea exc Tro Dep Kidney Tro Los Free	logical rful, anxious essive worry uble sleeping oression uble starting urine s of urine with cough quent nighttime urina	/sneeze
eview of seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly yes & Ears Dry eyes Change in	Systems: (I ss ats petite n mph nodes vision earing	eled outside	ies/hobbies the United any of the form End Gas —————————————————————————————————	?	he last 6 models Please checolomics Illumsiness Inbness of extra tolerance nation irst Initing December 1	onths?k)	Psycho Psycho Fea exc Tro Dep Kidney Tro Los Free Muscul Pain	logical rful, anxious essive worry uble sleeping oression uble starting urine s of urine with cough quent nighttime urina	/sneeze ation
eview of seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly yes & Ears Change in	Systems: (I ss ats petite n mph nodes vision earing	eled outside	ies/hobbies the United any of the fo	?	he last 6 models Please checolomics Illumsiness Inbness of extra tolerance nation irst Initing December 1	onths?k)	Psycho Psycho Fea exc Tro Dep Kidney Tro Los Free Muscul Pair	logical rful, anxious essive worry uble sleeping pression uble starting urine s of urine with cough quent nighttime urina oskeletal ful swollen joints scle tenderness or pa	/sneeze ation
eview of Seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly yes & Ears Dry eyes Change in Trouble he	Systems: (I ss ats petite n mph nodes vision earing	eled outside	ies/hobbies the United any of the fo	?	he last 6 models Please checolomics Illumsiness Inbness of extra tolerance nation irst Initing December 1	onths?k)	Psycho Peace Exc Tro Dep Kidney Tro Los Free Muscul Muscul Mu	logical rful, anxious essive worry uble sleeping pression uble starting urine s of urine with cough quent nighttime uring oskeletal nful swollen joints scle tenderness or pa	/sneeze ation
eview of Seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly yes & Ears Dry eyes Change in Trouble he	Systems: (I ss ats petite h emph nodes vision earing ears	eled outside	ies/hobbies the United any of the fo	States in to Dillowing? In Incological Weakness/c Tingling/num Ocrine Cold/heat in Frequent uri Increased the trointestinal Nausea/Von Diarrhea Change in both Trouble swalleartburn	he last 6 models Please checolomics Illumsiness Inbness of extra tolerance nation irst Initing December 1	onths?k)	Psycho Peace Exc Tro Dep Kidney Tro Los Free Muscul Muscul Mu	logical rful, anxious essive worry uble sleeping pression uble starting urine s of urine with cough quent nighttime urina oskeletal ful swollen joints scle tenderness or pa	/sneeze ation
eview of Seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly res & Ears Dry eyes Change in Trouble he Ringing in	Systems: (I sss ats petite h emph nodes vision earing ears	reled outside	ies/hobbies the United any of the 6	?	he last 6 models Please checolomics Illumsiness Inbness of extra tolerance nation irst Initing December 1	onths?k)	Psycho Peace Exc Tro Dep Kidney Tro Los Free Muscul Muscul Mu	logical rful, anxious essive worry uble sleeping pression uble starting urine s of urine with cough quent nighttime urina oskeletal nful swollen joints scle tenderness or pa scle weakness normal bone density	/sneeze ation
eview of Seneral Weight loss Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly Ves & Ears Dry eyes Change in Trouble he Ringing in Skin rashe	Systems: (I ss ats petite h emph nodes vision earing ears	reled outside	ies/hobbies the United any of the formula in the Care and	States in to Dillowing? In States in to Dillowing? In States in the Including Increased the Increased the Increased the Increased Increa	he last 6 models he last 6 models he last 6 models have been so feather tolerance nation irst hitting lowel habits llowing	onths?k)	Psycho Psycho Fea exc Tro Dep Kidney Tro Los Free Muscul Pain Mu Abr	logical rful, anxious essive worry uble sleeping pression uble starting urine s of urine with cough quent nighttime urina oskeletal nful swollen joints scle tenderness or pa scle weakness normal bone density	/sneeze ation
eview of Seneral Weight lose Fevers Night swe Loss of ap Dry mouth Snoring Swollen ly yes & Ears Dry eyes Change in Trouble he Ringing in skin Skin rashe	Systems: (I ss ats petite n mph nodes vision earing ears	reled outside	ies/hobbies the United any of the form End Gas Gas Car Car	States in to Dillowing? Incological Weakness/c Tingling/num Ocrine Cold/heat in Frequent uri Increased the trointestinal Nausea/Von Diarrhea Change in both Trouble swa Heartburn diovascular Chest pain	he last 6 models he last 6 models he last 6 models have been determined by the last he	onths?k)	Psycho Psycho Fea exc Tro Dep Kidney Tro Los Free Muscul Pain Mu Abr Gyneco	logical rful, anxious essive worry uble sleeping bression uble starting urine s of urine with cough quent nighttime urina oskeletal nful swollen joints scle tenderness or pa scle weakness normal bone density	/sneeze ation

Getting a yearly flu shot is the best way to prevent getting influenza. Influenza can be dangerous for peol chronic diseases. We recommend a yearly flu shot for all our allergy patients who have no contraindications have any questions concerning the flu vaccine	•
Patient/Parent Signature(Please type first and last name if electronic signature)	-
Medical Provider's Initials (indicates the form has been reviewed)	_Date