

Patient's Name: _____
PCP: _____

Date: _____
Referred by: _____

What is your primary complaint? (check only one) Hayfever/Allergy Headaches Sinus infection Skin rash
 Respiratory/lung problems/asthma – including cough Other _____

How long? _____ Seasonal Year round

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Exposure(s)

Which seasons are symptom-free? Spring Summer Fall Winter **How many months are symptom free?** _____
 Yes No **Do your symptoms clear when you are out of Dallas?**

When are your symptoms worse? Indoors Outdoors Can't tell

Describe your symptoms.

Around fresh cut green grass in spring or when mowing? Mild Moderate Severe N/A

Sept/Oct with Ragweed pollen (State Fair time)? Mild Moderate Severe N/A

March and April with tree pollen? Mild Moderate Severe N/A

December - February with Mountain Cedar pollen? Mild Moderate Severe N/A

When house/garage is being cleaned or swept? Mild Moderate Severe N/A

Lying/sitting on old carpet or old, overstuffed furniture? Mild Moderate Severe N/A

When lying on feather pillow? Mild Moderate Severe N/A

Around dead grass (scalping the yard), compost piles, hay or straw (circus, barnyard) or raking leaves?
 Mild Moderate Severe N/A

During a dusty wind ("Norther" or West Texas dust storm) Mild Moderate Severe N/A

When around animals or livestock? Mild Moderate Severe N/A

Which animals increase symptoms? dogs cats horses rabbits cows sheep/goats
 chickens/geese parrots/canaries/other caged birds

When you smoke? Mild Moderate Severe N/A

Around second hand smoke? Mild Moderate Severe N/A

When opening a new, folded newspaper, around perfumes, powder, new clothing or in fabric stores?
 Mild Moderate Severe N/A

With insecticides or insect sprays? Mild Moderate Severe N/A

On Ozone alert days? Mild Moderate Severe N/A

Review of Systems

Do you have trouble with any of the below symptoms that have occurred in the last six weeks? Please check applicable ones.

General

- Fatigue
- Flu-like symptoms (aches/muscle pain)
- Insomnia/difficulty sleeping
- Excessive weight gain/loss (>10 pounds)

Head

- Dandruff Hair loss
- Scalp itching
- Headache/migraine

Eyes

- Burning Red Watery Swollen
- Thick secretions
- Eyelids Itchy Red/swollen Rash
- Last ophthalmology visit: Date _____
- Report: _____

Ears

- Blocked Dizziness (unsteady)
- Ear drainage Fluid-like feeling
- Itching Infections
- Pain Popping
- Ringing Vertigo (spinning)

Nose/Sinuses

- Nose bleeds Snoring Mouth breathing
- Severe itching
- Congestion - On average how often?
_____/7 mornings _____/7 evenings
- Runny nose - Clear Yellow/green White/gray
 Thick Watery
- Sinus pressure
- Sinus infections # in the past year _____
- Approx Dates Treatment Physician
- _____
- _____
- _____
- Current/unresolved infection
- Loss of sense of smell

Throat

- Post nasal drainage - Thin Thick Abundant
- Itching of roof of mouth/back of throat
- Frequent clearing of throat Hoarseness Dry throat
- Sore throat - Constant AM
- Tonsillitis in the past year Ulcers in the mouth
- Choking Tight throat Sensation of lump in throat
- Food catching in throat

Gastro-intestinal

- Acid in throat Belching Heartburn
- Constipation Cramping
- Diarrhea/diarrhea alternating w/constipation
- Sudden pain in abdomen accompanied by swelling of any body part

Respiratory

- Cough Tight chest
- Shortness of breath Frequent bronchitis
- Daytime or morning wheezing or asthma/# per week ____
- Awakening PM w/wheezing or asthma/# per week ____
- Wheezing with exercise Wheezing with laughter
- Smoker

Cardiac

- Anemia
- Irregular heartbeat or palpitations

Skin

- Eczema or itchy rash - where? _____
- Fever blisters Hives/welts
- Severe swelling of face/lips, etc

Endocrine

- Drowsiness
- Heat or cold intolerance
- Hormone replacement therapy

Genito-Urinary

- Difficulty with decongestants
- Frequent urinary tract infections
- Frequent yeast infections
- Prostate surgery

Neurological

- History of seizures
- A.D.D. or hyperactive

Musculo-Skeletal

- Muscle cramps/pain Joint aches Arthritis
- Swollen/tender joints T.M.J.

Psychiatric

- Anxiety
- Difficulty concentrating
- Depression
- Excessive work stress
- Nervousness

Past Allergy History

Please list **CURRENT** and **PREVIOUS ALLERGY** medications you have taken (prescription & over-the-counter medications) Circle the ones you are currently using.

Medication

_____ Taken Regularly As Needed Helped Failed Partial help

_____ Taken Regularly As Needed Helped Failed Partial help

_____ Taken Regularly As Needed Helped Failed Partial help

_____ Taken Regularly As Needed Helped Failed Partial help

Do you have Insect Allergy? N/A fire ants honeybee wasp yellow jacket other

Details: _____

Previous Corticosteroid Use

Yes No Have you used oral or injectable cortisone medications? *If yes, please complete.*

Reason for use of cortisone? _____,

Shot Pill Length of treatment _____ Last year of treatment _____ # of prescriptions/shots _____

Previous Allergy Testing & Treatment

Yes No Have you ever had allergy testing? If yes, approximate year _____

Type: Skin Tests RAST Other _____

Physician _____ Reason for Transfer _____

Yes No Were you on allergy shots? If yes, duration? From (mo/year) _____ to (mo/year) _____

Yes No Are you still on allergy shots regularly? If yes, how often do you take them? _____

Past Medical History

Yes No Are you allergic to any medications?

Please list any known drug allergies, estimated year of occurrence, and reaction (e.g. rash, wheezing, flushing, etc.)

What? _____ Approx year: _____ Reaction: _____

What? _____ Approx year: _____ Reaction: _____

Please check if Yes and indicate approximate year diagnosed.

Past Illnesses:

Pneumonia Year _____ # _____

Bronchitis Year _____ # _____

Asthma Year _____

Hayfever Year _____

Colitis Year _____

Influenza Year _____

Diabetes Year _____

Stomach ulcer Year _____

Tuberculosis Year _____

Hypertension Year _____

Cancer Year _____

Type _____

Heart attack Year _____

Stroke Year _____

Coronary artery dis. Year _____

Autoimmune disease Year _____

HIV Year _____

Hepatitis B Year _____

Hepatitis C Year _____

Thyroid Disease Year _____

Glaucoma/cataracts Year _____

History of nasal polyps Year _____

History of sinus polyps Year _____

Major Events or Surgeries:

Yes No Have you ever had surgeries/procedures performed by an Ear, Nose, Throat surgeon?
Event _____ Approx. year _____

Respiratory

Yes No Have you ever had respiratory-related emergency room visits or hospitalizations (such as asthma, bronchitis, pneumonia, or anaphylactic shock?)
Event _____ Approx. year _____

Other hospital/surgery _____

Pregnancies:

Yes No Are you pregnant now? Due date: _____
 Yes No Are you breast-feeding now?

Immunizations and Other Procedures:

Yes No Have you had a Pneumovax or pneumonia shot? Approx. year _____
 Yes No Have you had a tetanus shot? Approx. year _____
 Yes No Have you ever had an immune evaluation?
 Yes No Have you ever had a psychiatric evaluation?
 Yes No Have you ever used recreational drugs?

Have you ever had a CT scan or MRI of your sinuses? Year _____ Normal Abnormal
 Sinus x-rays? Year last performed _____ Normal Abnormal
 Rhinoscopy (scope) of the nose/sinuses? Year _____ Normal Abnormal

Family Medical History

Check any members of your family who have had the following:

Asthma father mother brother sister Hayfever/Nasal Allergy father mother brother sister
Migraine father mother brother sister Frequent Headache father mother brother sister
Eczema father mother brother sister Angioedema/Urticaria father mother brother sister
Colitis/IBS father mother brother sister

Food sensitivities – Does anyone in your immediate family have food allergies or sensitivities? *If so, please list (include parents, siblings, grandparents, aunts and uncles).*

Who _____ Food(s) _____ Symptom(s) _____
Who _____ Food(s) _____ Symptom(s) _____

Answer the following for immediate family members.

Father: Is your father living? If living, age now: _____ Major health problems: _____
If deceased, age at death _____ Cause of death _____

Mother: Is your mother living? If living, age now _____ Major health problems: _____
If deceased, age at death _____ Cause of death _____

Siblings: History of any Immune Deficiency?

Are any of your siblings deceased? Yes No

Age at death _____ Cause _____ Age at death _____ Cause _____

List any major health problems of your siblings: _____, _____,
_____, _____,

Environmental History

Please check all that apply to your environment.

Primary Residence

Do you Own your home Rent or Live with relatives ?

What year was your home built? _____ How many years have you lived there? _____

Location City Rural Construction Brick/Stone Frame

Yes No Has your home flooded? Source: Outdoor or leak from Roof Broken pipe Water heater
 Other _____

Yes No Were carpets replaced after flooding?

AC/Heater Type: Central Floor heater Electric space heater Window unit AC

Type of Filters: Store Brand 3M Dust Guard Aller-X Electrostatic

Floors: (If you have carpet, please give approximate age.)

Bedroom: Carpet: Age _____ Hardwood Tile Linoleum

Family/Living Room: Carpet: Age _____ Hardwood Tile Linoleum

Bedding:

Type: Mattress/Box Springs Waterbed Futon Other _____ Approx Year Purchased _____

Yes No Is your bed encased in a dust proof mattress protector?

Please check bedding that you have:

Dacron/Poly pillows Feather/down comforter or pillows Foam pillow/egg crate

Feather bed Old quilts/mattress pad/stuffed animals

ف Yes No Bed propped up? If yes, how? Bricks # _____ Pillows Wedge
Approx. number of inches _____

Sleep habits: Sleep with windows open Sleep with ceiling fan or oscillating fan on face

Pets/Livestock:

Yes No Do you have Pets/Livestock:

Type _____ # _____ Exposure: Outside Inside Sleeps in bedroom Sleeps in bed

Type _____ # _____ Exposure: Outside Inside Sleeps in bedroom Sleeps in bed

Yes No Smokers in your house? If yes, Self Spouse Parents Children In-laws

Yes No Have you had heavy insecticide use or termite treatment in your home?

Work/School: Does your job worsen your condition? Yes No

Are you exposed to any of the following?

Smokers Work Outside Work in warehouse Remodeling Chemicals Old carpet/lots of dust

Second home:

Yes No Do you have a second home ? (vacation, college, etc.) If yes, please complete.

Location _____ Time spent per year _____ Days Weeks Months

Yes No Flooding

BEDDING: Mattress/box springs Other _____ Old Carpet

Social History

Occupation _____ Total hours worked per week _____
 (Include second job if applicable)

How many days did you miss school or work in the past year due to illness? _____
 How many days did you attend school or work while ill in the past year? _____

Education: Grade finished _____ Some college Bachelors degree Grad/professional degree

Ethnicity (optional): African Asian Caucasian Hispanic
 Yes No Do you have dietary or religious restrictions due to your ethnic group?

Language: Primary language: English Spanish Vietnamese Other _____
 If not English, do you speak and understand English? Yes No

Hobbies: _____

Exercise: Do you exercise regularly? Yes No Type: Walking Jogging Cross-train Biking Other ____
 How often _____ # of times per week _____ # of minutes at each session _____

Yes No Do you use tobacco? or have you in the past? *If yes, complete the following:*
 Type: Cigars Cigarettes Pipe Chew Snuff
 Status: Past Present Recreational
 If cigarettes, # of cigarettes per day _____ Year started smoking _____
 If other, amount _____ per day week month
 If past use, when did you discontinue? Approximate year _____

Yes No Do you use alcohol?
 Type: Beer Wine Liquor Other _____
 How often? Daily >1 time per day 3-4/week 1-2/week Occasional

Yes No Do you use caffeine products?
 Type: Coffee Soft drinks Tea
 How often?: Daily >1 time per day 3-4/week 1-2/week Occasional

Diet History

Current diet – *Frequency of intake (# of days per week)*

Milk _____ Wheat/Bread _____ Corn _____ Wine _____
 Dairy _____ Chocolate _____ Egg _____ Other _____
 Beef _____ Peanut _____ Beer _____

Food and food additive sensitivities – Are you allergic or sensitive to any FOOD, beverage, or additive?

Food/additive	Symptom(s)	Frequency Eaten #/week
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Yes No Do you eat outside the home? If yes, how many times a week? _____

Yes No Is there a history of food poisoning?