Vero ENT Allergy Center

*Date:*_____

Patient Name: _____ Age: _____ Sex: ___ DOB: _____
Parent: _____ Phone: _____
Address: _____ Occupation: _____
City: _____ St: ___ ZIP: _____ Patient Number: _____

A. Major Complaints: (list each and when started)

1. _____
2. _____
3. _____
4. _____

B. General Symptoms: (check beside each symptom)

1. Pollen Allergy	**2. Dust Allergy**	**3. Mold Allergy**	**4. Contact Allergy**
_Worse outdoors	_Worse indoors	_Worse outdoors from 4 to 9 pm	_Worse with lights on
_Worse on windy days	_Better outdoors	_Worse on cool evenings	_Worse in specific rooms
_Worse on clear days	_Worse 30 minutes after retiring	_Worse in low, damp places	Which: _____ _____
_Worse outdoors 7 to 11 am	_Worse in cold weather	_Worse mowing or playing in grass	_Worse in basement
Worse in change of temperature	_Worse when sweeping	_Worse on windy days	_Worse near barn
_Worse in warm or cool air	_Worse when dusting		_Worse around animals
_Better indoors			Which: _____ _____
_Better outdoors			

5. Are symptoms constant or intermittent:_____?

6.During which months do you usually have symptoms			**7. During which months are symptoms most severe**		
_January	_June	_November	_January	_June	_November
_February	_July	_December	_February	_July	_December
_March	_August	_All	_March	_August	_All
_April	_September		_April	_September	
_May	_October		_May	_October	

8. How and when did the conditions begin: _____
_____
_____

9. Do you have an animal in the home?_____

10. Have you ever had an anaphylactic reaction and if so to what_____

C. Medical Information

1. What medications (prescription and OTC) do you take?

Aspirin	Birth Control	Nose drops/sprays	List others
Cortisone	Antibiotics	Hormones	
Tranquilizers	Vitamins	Antihistamines	
High Blood Pressure medication	Ointments	Decongestants	
Sedatives	Thyroid medication	Anticholesterol medications	

2. Which medications relieve allergy symptoms: _____