



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
<input type="checkbox"/> Worse outdoors	<input type="checkbox"/> Worse indoors	<input type="checkbox"/> Worse outdoors from 4 to 9 pm	<input type="checkbox"/> Worse with lights on
<input type="checkbox"/> Worse on windy days	<input type="checkbox"/> Better outdoors	<input type="checkbox"/> Worse on cool evenings	<input type="checkbox"/> Worse in specific rooms
<input type="checkbox"/> Worse on clear days	<input type="checkbox"/> Worse 30 minutes after retiring	<input type="checkbox"/> Worse in low, damp places	Which: _____
<input type="checkbox"/> Worse outdoors 7 to 11 am	<input type="checkbox"/> Worse in cold weather	<input type="checkbox"/> Worse mowing or playing in grass	<input type="checkbox"/> Worse in basement
<input type="checkbox"/> Worse in change of temperature	<input type="checkbox"/> Worse when sweeping	<input type="checkbox"/> Worse on windy days	<input type="checkbox"/> Worse near barn
<input type="checkbox"/> Worse in warm or cool air	<input type="checkbox"/> Worse when dusting		<input type="checkbox"/> Worse around animals
<input type="checkbox"/> Better indoors			Which: _____
<input type="checkbox"/> Better outdoors			

5. Are symptoms constant or intermittent: \_\_\_\_\_?

**6. During which months do you usually have symptoms**

<input type="checkbox"/> January	<input type="checkbox"/> June	<input type="checkbox"/> November
<input type="checkbox"/> February	<input type="checkbox"/> July	<input type="checkbox"/> December
<input type="checkbox"/> March	<input type="checkbox"/> August	<input type="checkbox"/> All
<input type="checkbox"/> April	<input type="checkbox"/> September	
<input type="checkbox"/> May	<input type="checkbox"/> October	

**7. During which months are symptoms most severe**

<input type="checkbox"/> January	<input type="checkbox"/> June	<input type="checkbox"/> November
<input type="checkbox"/> February	<input type="checkbox"/> July	<input type="checkbox"/> December
<input type="checkbox"/> March	<input type="checkbox"/> August	<input type="checkbox"/> All
<input type="checkbox"/> April	<input type="checkbox"/> September	
<input type="checkbox"/> May	<input type="checkbox"/> 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: \_\_\_\_\_