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Patient History

Are you scheduling for allergy or asthma evaluation? Yes No

Are you scheduling for immune evaluation? Yes No

What are your symptom(s) that bothers you the most? _____

ALLERGY HISTORY

Have you been diagnosed with allergies? Yes No

Do you experience runny nose, congestion, and sneezing? Yes No

Do you have itchy, watery eyes? Yes No

When are your symptoms present? Spring Fall Year-round Around animals, dust or pollen

Do you have history of sinus infections? Yes No

Do you have history of ear infections? Yes No

Have you had allergy testing before? Yes No

If yes, what type of testing was it? Skin testing Lab testing

Have you ever had a sinus CT scan? Yes No

Have you ever been to a ear, nose and throat specialist? Yes No

Have you ever had surgeries for sinus, ear tubes, adenoids, or tonsils? Yes No

What medications have you tried for you symptoms? Benadryl Claritin Zytec Allegra
 Clarinex

LOWER RESPIRATORY HISTORY

Do you have a history of asthma? Yes No

Do you have cough, shortness of breath? Yes No

If yes, with activity or at nighttime?

Do your symptoms get worse with the following? Illness Exercise Cold air Lying down

Have you ever had pneumonia or bronchitis? Yes No

Have you ever had a CXR or a Chest CT? Yes No

What medications have you used for the above symptoms?

Albuterol Advair Flovent QVAR Asmanex Symbicort?

SKIN HISTORY

Do you have history of eczema or hives? Yes No

Do you have symptoms of itchy, red or scaling skin? Yes No

If yes, do the following make your symptoms worse?

Animals Winter season Illness Symptoms present year-round

Have you had the following skin infections? Cellulitis Impetigo

What medications have you tried?

Elidel Acclovate Triamcinolone (topical steroid) Daily moisturizer (lotion)

(continued)

FOOD ALLERGY HISTORY

Do you have a history of food allergies? Yes No
Do you experience itching around or in mouth, hives or vomiting? Yes No
Have you had an epipen prescribed? Yes No

ADDITIONAL ALLERGY HISTORY

Do you have any allergies to bee or insect stings/bites? Yes No
Do you have any allergy or sensitivity to latex? Yes No

GI HISTORY

Do you have a history of Gastrointestinal Disorders? Yes No
 Irritable Bowel Syndrome Crohn's Disease Ulcerative colitis GERD Lactose intolerance
Do you have symptoms of diarrhea, constipation, heartburn, difficulty swallowing? Yes No
Do you have a history of GI infections? Yes No
Do you have a history of giardia? Yes No
What medications have you tried? _____

What foods have you tried to eliminate from your diet? _____

Did that help? Yes No
What testing have you had performed? UGI Endoscopy
Have you seen a GI specialist? Yes No

IMMUNE HISTORY

Have you had any other infections not addressed above? Yes No
Do you feel that you are sick often? Yes No
Have you had a lot of antibiotics overall? Yes No
How many antibiotics in the last year? _____
Have you had any hospitalizations or surgeries related to infections? Yes No

IMMUNE-RELATED HISTORY

How is your energy? _____
Do you have Chronic Fatigue? Yes No
Do you have joint pain? Yes No
Do you have a history of: Fibromyalgia Rheumatoid Arthritis
Do you have recurrent fevers? Yes No
Do you have tingling or numbness? Yes No

PAST MEDICAL HISTORY

Prior surgeries: _____
Hospitalization or emergency room visits: _____
Do you have a history of immune disorders? Yes No
Do you have a history of autoimmune disorders? Yes No
Do you have a history of thyroid disorders? Yes No

FAMILY HISTORY

Is there a history of allergies, asthma, immune or autoimmune disorders in your family? Yes No

(continued)

SOCIAL HISTORY

What is your occupation? _____

What type of environment do you work in? _____

Is your work affected by your symptoms? Yes No

ENVIRONMENTAL HISTORY

Location: city suburb country/farm

Structure: house apartment

age of building _____ number of years at this address _____

recent painting or repairs _____

Basement: slab finished dry damp mildew

Flooring: hardwood carpet—(wool synthetic)

padding—(rubber ozite other)

Furniture: new antique

Window Treatments: drapes blinds shades

Heating System: hot air hot water electric baseboard.

Fuel: gas electric coal oil other _____

Air Filters: fiberglass electrostatic HEPA other _____

Air Conditioning: central window unit humidifier dehumidifier

Bedroom Windows Open: day night winter summer

Bedding: mattress cover: cotton pad allergy proof

box spring cover: cotton allergy proof

pillows: feather polyester kapok

comforter: cotton down other _____

Pets: cat dog bird other _____

frequent contact: in house with access to bedroom

Infestation: cockroaches mice rats

Smoking: patient family member co-workers other _____

