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Patient's Name: _____ Date of Birth: _____

Referred by: _____ Primary Dr:_____

Appt Date: _____ Today's Date: _____

Instructions: Please answer the questions on this form as related to the person being evaluated. A complete and accurate record is important in learning about your allergy problem. Please bring the completed form with you for your first appointment.

I. I have come to this office because: _____
_____

II. SYMPTOMS (CIRCLE ALL THAT APPLY)

EYES : ITCHY DRY WATERY "GRITTY" FEELS LIKE SAND IN MY EYES

EARS: FULL FEELING PAIN POPPING CLICKING PRESSURE DIZZINESS VERTIGO ITCHY

NOSE : STUFFY (RIGHT SIDE LEFT SIDE) RUNNY SNEEZING ITCHY MUCOUS : (CLEAR YELLOW GREEN)

THROAT: SORE SCRATCHY POST NASAL DRIP COUGH THROAT CLEARING TROUBLE SWALLOWING

SINUS: HEADACHE PAIN PRESSURE (RIGHT SIDE LEFT SIDE) DECREASED SENSE OF SMELL TASTE

CHEST: COUGH WHEEZING SHORTNESS OF BREATH TIGHTNESS PAIN CONGESTION

SKIN: RASH HIVES BLISTERS ITCHY WORSE AT: NIGHT DAYTIME

GI: ACID/ INDIGESTION NAUSEA/ VOMITING

GENERAL: FEVER SWEATS CHILLS FATIGUE "FEELING ILL" MUSCLE WEAKNESS SWELLING

HOW LONG HAVE YOU HAD THESE SYMPTOMS? _____

PATIENTS PLEASE CONTINUE TO THE NEXT PAGE. → → → → → → → → → →

Doctor's Evaluation – DO NOT WRITE BELOW THIS LINE.

_____
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_____**This page reviewed with patient by Dr. Danziger**

III. TRIGGERS OF YOUR SYMPTOMS: (CIRCLE ALL THAT APPLY) POLLEN MOLD DUST

CATS DOGS OTHER ANIMALS _____ CLEANING FLUIDS CHEMICALS

PERFUME CIGARETTE / CIGAR SMOKE NEWSPRINT CHANGES IN WEATHER

COLD FRONTS RAINY WEATHER WINDY WEATHER EXERCISE STRESS

SYMPTOMS ARE WORSE: JAN FEB MAR APR MAY JUN JUL AUG SEPT OCT NOV DEC

IV. FOOD REACTIONS: (I.E. ABDOMINAL PAIN, HIVES, SWELLING, NASAL CONGESTION, ETC):

_____
_____
_____
_____

V. INSECT STING REACTIONS: (I.E. MILD, MODERATE, OR SEVERE; INCLUDE DATES OF MORE SEVERE REACTIONS AND DETAILS):

_____
_____
_____

VI. MEDICATION REACTIONS: (INCLUDE NAME, DATE AND DETAILS OF ALL REACTIONS):

_____
_____
_____

HAVE YOU EVER HAD A REACTION TO X-RAY DYE? YES NO DETAILS: _____
HAVE YOU EVER HAD A REACTION TO LATEX? YES NO DETAILS**:** _____

VII. PREVIOUS ALLERGY EVALUATION & TREATMENT: (PLEASE LIST IF YOU HAVE SEEN AN ALLERGY OR ENT SPECIALIST IN THE PAST, DATES AND RESULTS OF TESTS): _____

_____
_____

WERE YOU EVER ON REGULAR ALLERGY INJECTIONS? YES NO **HOW LONG?** _____
WERE ALLERGY INJECTIONS HELPFUL? YES NO **RESPONSE:** POOR FAIR GOOD EXCELLENT

VIII. ENVIRONMENT:

Do you live in a/an: ☐ House ☐ Apartment ☐ Condo ☐ Mobile Home ☐ Duplex ☐ Townhouse

Is it located on/near: ☐ Lake / pond ☐ Vacant land ☐ Industrial area ☐ Canal / bay / ocean
Age of house: _____ years Single or Two-story_____ Is there mildew present?_____ Indoor flood? _____
How long have you lived there: _____ years / months Any air conditioner problems? _____
Type of air conditioning: (central, window, etc.) _____
Type of flooring: (carpet, wood, tile, vinyl, etc.) _____ Is it: throughout____ In bedrooms____in living room____
How old is your mattress? _____yrs/months

Is your mattress: ☐ Foam ☐ Innerspring ☐ Encased in plastic ☐ Cotton ☐ Waterbed ☐ Other _____

How old is your pillow? _____ years / months Is your pillow: ☐ Feather ☐ Synthetic(Dacron) ☐ Foam ☐other _____

Does your child have stuffed animals? ☐ Many ☐ Few ☐ None
Do you have any pets? _____ List number and kind (i.e. dog, cat, bird, etc.)_____
_____
Do the pets sleep in your bedroom?_____ Are there smokers present in the home?_____

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IX: WORK HISTORY/ ENVIRONMENT:

What is your occupation?_____

Where are you employed?_____ How long have you worked there?_____

Is your work environment: ☐ carpeted ☐ tiled ☐ other_____

Are you exposed to chemicals or strong odors or dust / mold at work? _____

If yes, please specify:_____

Are your symptoms worse at work? ☐ Yes ☐ No If yes, please specify_____

Have you missed any time from work because of your allergies? _____

X. SCHOOL HISTORY/ENVIRONMENT:

What school do you attend? _____ What grade/level? _____

Is your classroom: ☐ Carpeted ☐ Tiled Is there a problem with mold? _____

Do you participate in physical education? _____ Does exercise cause shortness of breath? YES NO

Have you missed any time from school because of your allergies?_____ How many days missed last year?____

Do you feel school performance has been affected by allergies? _____

Comments:_____

XI. MEDICATIONS: Please list all medications below.

Drug	Dose	Date Started	Drug	Dose	Date Started

XII. PAST MEDICAL HISTORY: **Please list any Surgeries/ Hospitalizations/ Medical Conditions**.

Hospital or Dr. Treating	**Reason** (specific surgery or medical condition)	**Date**
Have you ever had pneumonia? Y N	If so when? Hospitalized?	___Yes ___No

Dental History: Have you ever worn braces? _____ Do you wear dentures? _____

XIII. IMMUNIZATIONS : Are immunizations up to date? YES NO

Have you ever received Pneumovax (pneumonia vaccine)? YES NO If so, when? _____

Last flu vaccine (date): _____ Last tetanus vaccine (date): _____

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XIV. SYSTEMS REVIEW:

Females Only:
Are you periods regular? ___Yes ___No
Interval _____ Duration_____
At what age did they begin? _____

Males Only:
Prostate trouble? ___Yes ___No
Impotence? ___Yes ___No

What is your weight now? _____ What was your weight one year ago? _____
Do you have any other chronic symptoms?
_____
Have you ever been tested for HIV? (Circle one) Yes No Date: _____ Positive Negative
Have you ever been treated for alcohol or substance abuse? (Circle one) Yes No Date: _____

XV. BIRTH HISTORY: (FOR PEDIATRIC PATIENTS) WAS MOTHER'S PREGNANCY FULL TERM? YES NO
BIRTH WEIGHT:_____ BREAST FED? YES NO HOW LONG? _____

ANY COMPLICATIONS DURING PREGNANCY ? YES NO DETAILS: _____

ANY COMPLICATIONS DURING DELIVERY ? YES NO DETAILS: _____

ANY COMPLICATIONS IN FIRST 3 MONTHS OF LIFE ? YES NO DETAILS: _____

XVI. SOCIAL: WHERE WERE YOU BORN? _____ RAISED? _____

WHEN DID YOU MOVE TO FLORIDA? _____ MARITAL STATUS: S / M / D / W
WHERE ELSE HAVE YOU LIVED? (INCLUDE DATES): _____
_____
HOW MANY CHILDREN DO YOU HAVE? (MALE/FEMALE, AGE): _____
_____
DO YOU EXERCISE? YES NO HOW OFTEN AND FOR HOW LONG?_____
ALCOHOL INTAKE: (HOW MUCH, HOW OFTEN): _____

XVII. SMOKING: HAVE YOU EVER SMOKED? YES NO HOW MANY YEARS? _____

STOPPED? YES NO WHEN DID YOU STOP? _____ WHEN WILL YOU STOP? _____

NUMBER OF CIGARETTES PER DAY: _____ EXPOSURE TO SMOKE AT WORK? YES NO

OTHER FAMILY MEMBERS SMOKING? YES NO
INSIDE HOME? YES NO
INSIDE CAR? YES NO

XVIII. FAMILY HISTORY: PLEASE LIST BLOOD RELATIVES THAT HAVE THE FOLLOWING CONDITIONS:

HAY FEVER, "SINUS" _____ ASTHMA _____

ECZEMA _____ HIVES _____ SWELLING _____

MIGRAINE _____ HEADACHES _____ EMPHYSEMA _____

HEART ATTACK _____ HIGH BLOOD PRESSURE _____ CANCER _____

PNEUMONIA / BRONCHITIS _____

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