



Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

City, State, Zip: \_\_\_\_\_

Home#: \_\_\_\_\_

Gender (circle one):    **MALE**                      **FEMALE**

Work#: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

Referring Physician: \_\_\_\_\_

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program.*
- *There is no single “healthy” diet that will work for everyone.*
- *Just because food is considered “healthy”, does not mean it is “healthy” for you.*
- *Your diet consists of everything you **eat, drink, rub on your skin, or inhale.***
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish: \_\_\_\_\_

**AGE WHEN SYMPTOMS WERE FIRST OBSERVED**

- |  |   |
|--|---|
| <input type="checkbox"/> Infant (Age 0-2)        | <input type="checkbox"/> Child (Age 3-5)        |
| <input type="checkbox"/> Child (Age 6-12)        | <input type="checkbox"/> Adolescent (Age 13-18) |
| <input type="checkbox"/> Adult (Age 19-25)       | <input type="checkbox"/> Adult (Age 26-40)      |
| <input type="checkbox"/> Adult (Age 41 and over) |   |

**DID YOU SUFFER FROM ANY TYPE OF PHYSICAL, CHEMICAL OR EMOTIONAL TRAUMA JUST BEFORE YOUR SYMPTOMS WERE FIRST OBSERVED?** \_\_\_\_\_

**HAVE YOUR SYMPTOMS EVER GONE AWAY FOR ANY PERIOD OF TIME?** \_\_\_\_\_

**PREVIOUS DIAGNOSIS OF ALLERGY**

- Yes and allergy shots helped       Yes but allergy shots did not help
- Yes and medication helped       Yes but medication did not help
- None

**FAMILY MEMBERS WITH ALLERGIC SYMPTOMS**

- Mother                       Father
- Brother/Sister               Grandparents
- Son/Daughter               Spouse
- None

**FREQUENCY & SEVERITY OF ALLERGY SYMPTOMS**

- Constant/Chronic with little change       Present most of the time
- Present part of the time                       Present rarely
- Prevents some normal activities               Considerable interference with normal life
- Slight interference with normal life               No interference with normal life

**SYMPTOMS ARE WORSE**

- |   |  |
|---|--|
| <input type="checkbox"/> Outdoors and better indoors                      | <input type="checkbox"/> At nighttime                                    |
| <input type="checkbox"/> In the bedroom or when in bed                    | <input type="checkbox"/> During windy weather                            |
| <input type="checkbox"/> During wet or damp weather                       | <input type="checkbox"/> When the weather changes                        |
| <input type="checkbox"/> During known pollen seasons                      | <input type="checkbox"/> In certain rooms or buildings                   |
| <input type="checkbox"/> When exposed to tobacco smoke                    | <input type="checkbox"/> With yard work, cut grass, leaves, hay or barns |
| <input type="checkbox"/> When sweeping or dusting the house               | <input type="checkbox"/> In areas with mold or mildew                    |
| <input type="checkbox"/> In air conditioning                              | <input type="checkbox"/> In fields or in the country                     |
| <input type="checkbox"/> Tobacco smoke bothers me more than anything else |  |

**SYMPTOMS ARE BETTER**

- |  |  |
|--|--|
| <input type="checkbox"/> After shower or bath        | <input type="checkbox"/> In air conditioning               |
| <input type="checkbox"/> Indoors                     | <input type="checkbox"/> During or after physical activity |
| <input type="checkbox"/> After taking antihistamines | <input type="checkbox"/> With allergy shots                |

What makes you feel better? \_\_\_\_\_  
\_\_\_\_\_

**ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE**

- |   |                                      |  |
|---|--------------------------------------|--|
| <input type="checkbox"/> Dogs             | <input type="checkbox"/> Cats        | <input type="checkbox"/> Rodents (mice, guinea pigs, etc.) |
| <input type="checkbox"/> Horses or Cattle | <input type="checkbox"/> Rabbits     | <input type="checkbox"/> Birds or Feathers                 |
| <input type="checkbox"/> Bees             | <input type="checkbox"/> Other _____ |  |
| <input type="checkbox"/> None             |                                      |  |

### FOOD RELATED SYMPTOMS

- |  |   |
|--|---|
| <input type="checkbox"/> Symptoms flare 5-60 minutes after meals                     | <input type="checkbox"/> Some foods are craved or addictive |
| <input type="checkbox"/> The smell or odor of some foods increases symptoms          | <input type="checkbox"/> Some foods cause nasal symptoms    |
| <input type="checkbox"/> Some foods cause swelling of the mouth or tongue            | <input type="checkbox"/> Some foods cause rashes or hives   |
| <input type="checkbox"/> Some foods cause upset stomach or vomiting                  | <input type="checkbox"/> Some foods cause diarrhea          |
| <input type="checkbox"/> Symptoms occur with restaurant salad bars or Asian foods    | <input type="checkbox"/> Some foods cause headaches         |
| <input type="checkbox"/> Symptoms occur with any regularly eaten food                | <input type="checkbox"/> Some foods cause asthma            |
| <input type="checkbox"/> Preservatives, additives or food coloring increase symptoms | <input type="checkbox"/> No problem with foods              |

### FOODS THAT CAUSE SYMPTOMS FROM ONE HOUR TO THREE DAYS AFTER EXPOSURE

- |  |   |                                    |
|--|---|------------------------------------|
| <input type="checkbox"/> Eggs          | <input type="checkbox"/> Milk                   | <input type="checkbox"/> Beef      |
| <input type="checkbox"/> Corn          | <input type="checkbox"/> Wheat                  | <input type="checkbox"/> Soybean   |
| <input type="checkbox"/> Peanut        | <input type="checkbox"/> Pork                   | <input type="checkbox"/> Fish      |
| <input type="checkbox"/> Shellfish     | <input type="checkbox"/> Orange or other citrus | <input type="checkbox"/> Potato    |
| <input type="checkbox"/> Tomato        | <input type="checkbox"/> Yeast                  | <input type="checkbox"/> Chocolate |
| <input type="checkbox"/> Coffee or Tea | <input type="checkbox"/> Other _____            |                                    |
| <input type="checkbox"/> None          |   |                                    |

### CHEMICALS THAT CAUSE SYMPTOMS

- |   |   |
|---|---|
| <input type="checkbox"/> Insecticides & pesticides  | <input type="checkbox"/> Paints & household cleaners              |
| <input type="checkbox"/> Perfumes & cosmetics       | <input type="checkbox"/> Gasoline or automobiles exhaust          |
| <input type="checkbox"/> Stove or furnace emissions | <input type="checkbox"/> The smell of new fabrics or fabric store |
| <input type="checkbox"/> Chemicals in the workplace | <input type="checkbox"/> Laundry detergent                        |
| <input type="checkbox"/> Newsprint                  | <input type="checkbox"/> Other: _____                             |
| <input type="checkbox"/> None                       |   |

**WHEN ARE YOUR SYMPTOMS WORSE**

Year around

January

February

March

April

May

June

July

August

September

October

November

December

**MEDICATIONS**

Do you take any of the following medications on a regular basis?

Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc)

Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS's such as Primatine Mist, etc)

Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclovent, Aerobid, Advair, etc)

Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)

Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)

Chemotherapy

Please list any medications that you are currently taking: \_\_\_\_\_

\_\_\_\_\_

**SMOKING**

Do you presently smoke?  Yes  No      If yes, average number of cigarettes per day \_\_\_\_\_

If yes, at what age did you start? \_\_\_\_\_

Does anyone smoke in your home?  Yes  No

**PREVIOUS ALLERGY EVALUTION**

Have you ever seen an allergist?  Yes  No

Have you had allergy skin testing?  Yes  No

Did you have any positive reaction?  Yes  No

If yes, please list positive allergens (include any medications) \_\_\_\_\_

Have you ever received allergy injections?  Yes  No

**WORK ENVIRONMENT**

What is your occupation? \_\_\_\_\_

Are you exposed to chemicals or strong odors at work?  Yes  No

If yes, briefly explain \_\_\_\_\_

\_\_\_\_\_

Are you symptoms worse while at work?  Yes  No

If yes, briefly explain \_\_\_\_\_

\_\_\_\_\_

**ANY ADDITIONAL INFORMATION YOU WOULD LIKE US TO KNOW?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ANYTHING ELSE YOU WOULD LIKE TO ASK?** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_