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PLEASE ANSWER QUESTIONS BELOW TO THE BEST OF YOUR KNOWLEDGE

SEASONAL INCIDENT: Winter, Spring, Summer, Fall - Perennial

AGGRAVATING FACTORS: (Circle) Dust (Type _______________), Dog, Cat, Feathers, Cattle, Horses, Wool, Mohair, (Furniture, Sweaters, Etc.), Angora, Furs, Kapok, Barn, Hay, Tobacco (Housing, Around, Stripping), Colds, Odors (Cooking, Gas, Perfume, burning, Etc.), Cosmetics (Skin or Respiratory), Smoke, Leaves, Mowing, Pollen _______________. Plants _______________, Foods (worse after a meal) _______________, Fatigue, Exertion, Air Conditioning, Excitement, Worry, Weather (which type) _______________, Changes in Temperature, Drafts.

Are you worse indoors or outdoors, work or school? Is there a time of day worse for you – morning, afternoon, evening, night. Do you have frequent colds? If yes, how often _______________. How many times a year do you need antibiotics? _______________ Do you use nasal spray? _______________

INSECTS: Mosquito, Bee, Wasp, Etc. Local swelling: ___________________________ Systemic reaction: _______________________________

DRUG ALLERGY: (Drug name and describe whether local or systemic and symptoms)

PAST HISTORY:

YOUR Dr. Name:____ Date Last Seen:_____________

OTHER Dr. Name:____ Date Last Seen:_____________

PHYSICIANS Dr. Name:____ Date Last Seen:_____________

Serious illnesses: (with dates and location of hospital)

Injuries:

Immunizations: TB Skin Test Date: __________ Results: ___________________

Surgery: (type, date, location)

Colic: (from what and how long)

Eczema: (from what and how long)

“Sinus”

Hay Fever: (age of onset, how long, seasonal or perennial)

Asthma: (age of onset, how long, seasonal or perennial)

Hives:

PREVIOUS ALLERGY TESTS: When: _________________ From Whom: _____________________ Address: _________________________________

Treatment: _________________________________ How long: ___________________________ Results: _____________________________________

Medications: (currently using)

Weight loss or gain: (over how long) ________ Present weight ________ Height _________

Teeth: (false, filled, pain, gums) _______________ Date of last dental x-ray ______________

Skin: Rash (location, does it come and go) ____
Dandruff, athletes foot, toenails (hard cut), itching (when is it worse) ______________

Nose: Stopped up, Sneezing, Itching, Rubbing, Drainage from nose (clear, bloody, yellow, green, milky),
Sense of smell, Post nasal drainage (clear, bloody, yellow, green, milky), “Hawking”, Sniffling.

Throat: Soreness, Clearing, Hoarse, Difficulty in swallowing, Swelling, Itching.

Ears: Hearing OK (L or R), Noise, Dizzy, Ache, Fullness, Popping, Cracking, “Stopped up or full”, Itching (inside or outside)

Eyes: Itching, Tearing, Burning, Redness, Swelling, “Ropy” Secretions, Lids bother (swelling or matting)

Chest: Wheeze, Cough (sputum – bloody, yellow, green), Short of breath on exercise, at rest, at night – what time _______
Medicine used ____________________________, Chills, Night sweats

Cardiac: Rapid heart, palpitation, ankles swelling

X-ray: When _________, Where ________________________, Results _____________________________

G.I.: Appetite _______, Gas _______, Pain _______, Indigestion, Nausea, Vomiting, Diarrhea, Constipation,
Stools – bloody, tarry, mucous, worms, foamy, bulky. If any food products above, list:

Headache: Location __________________ Move any place _______________ How often ____________
How long does it last _________ Does it throb _______ (Beat, drum or pound with pulse) or is it steady,
Vomit, Nausea, Blind spots, Sweating, Flushing, Related to - (nose, eyes, tension, fatigue, period).
Warning ___________________________ Relieved by________________________________

G.U.: Frequency _______________, At night ______________, Burning, Bloody, Cloudy urine.

GYN: Regular \ Irregular periods ________, How affect allergy ________, Last period ________,
Hot flashes __________, Discharge __________, Itching __________,

Endocrine: Goiter, Prefer hot or cold weather, Dry skin, Joint pain, Fall asleep in chair,
Tired all the time, Difficulty thinking clearly, Thirsty, Frequent urination.

FAMILY HISTORY: Do any of the following, including Uncles, Aunts, Grandparents (either side), have asthma, hay fever, hives, eczema, sick headaches, sinus. Who: Father ________, Mother ________, Sisters ________,
Brothers ________, Others ____
If Married or Divorced, How long? ________ Children ________ Any Allergic? ________
Are they healthy? ____

SOCIAL:
Smoke _____ When Started _________ How Many _________________
Contacts at work – Dust, Fumes, Chemicals, etc. _____________________
Drink: Social __________ None __________ How Much ____________
Hobbies: ____

ENVIRONMENT:
Living conditions – _________________ Type of House – (Frame, brick, etc.) ____________
Basement – (moldy or dry) ______________ Plants in home _________________________
Pets – Dog, Cat, Bird - ____________________________________ Indoors or Outdoors
Furniture in house – Plastic, Cotton, Wool, Foam rubber, Feather or down _______________
Carpeting – What type _________________________________ Mat under it ____________
Heating system _____________________________________
Bedroom ____________ Books, Toys, Pillows (Feathers, Dacron, Foam, Plastic Cover),
Mattress (feathers, innerspring, cotton, foam, plastic cover), Drapes, Venetian Blinds,
Stuffed chairs, ___________ Rugs __________ How many and what type? ____________

N.P.: Nervous, Irritable, Blue or Depressed, Insomnia, Worried about something, Family, Children, Husband, Wife, Mother, Father, Job, etc