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TOPEKA ALLERGY & ASTHMA CLINIC ALLERGY HISTORY

Name: _____

Today's Date: _____

Address: _____

Age: _____ Date of Birth: _____

Occupation: _____

Telephone: (hm) _____ (wk) _____

Primary Care Physician: _____

(mobile): _____

Referring Health Care Provider: _____

Describe the problem (symptoms) that bothers you the most:

When did the problem start for the first time? _____

Is the problem changing? ____ Yes ____ No

If yes, describe how it is changing _____

Please check (✓) the months you have symptoms:

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

Has the patient ever seen an Ear, Nose and Throat doctor? Yes No

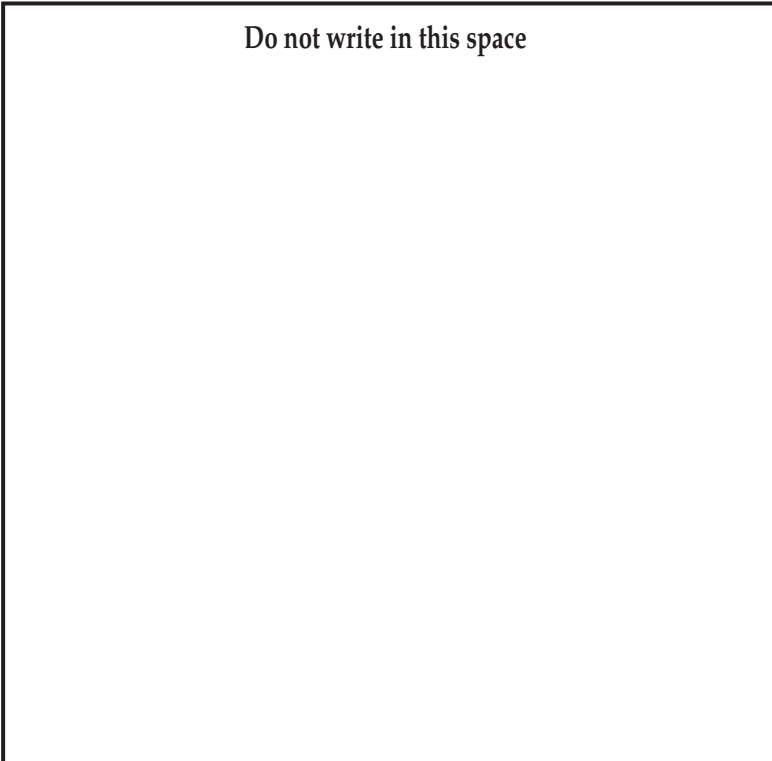
Has the patient had any allergy tests in the past? Yes No
(If yes, please describe:) _____

Has the patient ever had allergy injections? Yes No

Latex sensitivity: Yes No

Insect reactions? Yes No
(If yes, please describe:) _____

Food reactions? Yes No
(If yes, please describe:) _____



SYMPTOMS: Please check (✓) those that apply to you.

EYES

- itching
- watering
- burning
- bloodshot
- mattering

EARS

- draining
- popping and crackling
- ringing
- pain
- decreased hearing
- itching
- vertigo
- fluid behind drum

NOSE

- blocked-congested
- runny (clear, pus, blood)
- itching
- sneezing
- decreased taste-smell
- nasal trauma
- snoring
- mouth breathing

SINUSES

- cheekbone pain-pressure
- forehead pain-pressure
- nasal bridge-pressure
- bad smelling breath
- thick colored nasal discharge

THROAT

- throat tightness
- dry or scratchy
- difficulty swallowing
- hoarseness
- postnasal drip
- throat clearing of mucous
- itching

CHEST

- cough (dry, mucous, blood)
- pain
- tightness
- rattling sounds
- wheezing
- shortness of breath
- hyperventilation

SKIN

- hives
- eczema
- athlete's foot
- nail fungus
- dryness
- rash from poison ivy or oak
- rash from jewelry or metals

ABDOMEN

- heartburn and acid reflux
- bloating
- cramping
- nausea
- vomiting
- diarrhea
- constipation

GENERAL

- lack of energy
- easily tired out
- trouble sleeping
- weight loss/gain
- irritable
- poor appetite
- depressed
- excessive sweating
- nervous or anxious
- not refreshed by sleep
- fever +/- chills
- poor growth
- difficulty concentrating
- daytime sleepiness

JOINTS

- swelling
- redness
- ache or pain
- stiffness

Which of the following do you feel causes or worsens your symptoms?

Environmental:

- indoors
- outdoors
- on farms
- at lake
- damp basement
- grain elevators
- barns
- lawn mowing
- weather changes

Activities:

- exertion
- laughter
- crying
- nighttime
- arising in morning
- cold air
- prolonged talking

Irritants:

- tobacco smoke
- other smoke
- aerosols
- powders
- perfumes
- dusts
- paints
- fumes

Pets:

- cats
- dogs
- birds
- other _____

Infections:

- cold or "viruses"
- sinusitis
- chest colds
- croup

IF HEADACHES are significant for you, please complete this section.

Area

- forehead
- temples
- cheeks
- nape
- top of head
- behind eyes
- behind nasal bridge
- back of head

Pain

- aching
- pressure
- throbbing
- piercing
- tightness

Onset

- gradual
- sudden-abrupt

Duration

- hours
- days
- weeks

Frequency

- daily
- weekly
- monthly
- less often

Sleep required for relief? Yes No

Symptoms preceding or accompanying the headache

- watery eyes
- nasal congestion
- nausea
- vomiting
- change in vision, taste, hearing, or sense of smell
- photophobia

REVIEW OF SYSTEMS

- vision problems
- eyeglasses/contacts
- hearing problems
- hearing aid
- dentures

- palpitations
- heart murmur
- pacemaker
- ankle swelling

- blood transfusion
- jaundice (yellow skin)
- back pain
- leg pain

- difficulty urinating
- bloody urine
- menopause
- irregular menstrual cycle

- Pneumovax - year _____
- Influenza vaccine - year _____
- Tetanus vaccine - year _____

Has the patient had any of the following laboratory tests within the past 5 years?

- chest x-ray
- sinus x-ray
- CT sinus
- EKG (heart)
- lung function tests
- stress test
- sweat chloride
- gammaglobulin levels
- echocardiogram
- EGD
- mammogram
- colonoscopy

PAST MEDICAL HISTORY

BIRTH HISTORY (if pediatric patient less than 10 years of age):

Full term: Yes No

Breast fed: Yes No Reactions to formula (vomiting, spitting up, rash): _____

Birth weight: _____

Complications: Yes No

HOSPITALIZATIONS:

ER VISITS (reason):

Has the patient had any of the following conditions?

- hay fever
- deviated nasal septum
- sinus infection
- nasal and sinus polyps
- enlarged tonsils or adenoids
- frequent ear infections
- mastoiditis
- asthma
- croup
- pneumonia
- bronchitis
- emphysema
- eczema
- hives
- migraine headaches
- tension headaches
- heart disease
- high blood pressure
- increased cholesterol
- stroke
- diabetes
- thyroid problem
- ulcers
- hiatal hernia
- hepatitis
- irritable bowel
- cancer
- immune deficiency
- arthritis
- prostate enlargement
- kidney disease
- venereal disease
- meningitis
- glaucoma
- seizures
- chicken pox
- whooping cough
- mononucleosis
- HIV
- Lupus
- rheumatoid arthritis
- anemia
- osteoporosis

SURGERIES (list surgeries and dates):

CURRENT MEDICATIONS (including non-prescription medications): _____

Recently completed medications (steroids, antibiotics, and dates): _____

DRUG ALLERGIES (describe): _____

FAMILY HISTORY: Do any of your blood relatives have allergies or asthma?: _____

PAST ALLERGY THERAPY or DRUGS TRIED: _____

ENVIRONMENTAL SURVEY

1. You live in a
 single home
 duplex
 trailer
 apartment
 dormitory
 other
2. Location of home
 town
 country
 farm
 other
3. Age of home
 1 - 5 years
 6 - 10 years
 11 - 20 years
 over 20 years
 over 50 years
4. Years in home
 1 or less
 1 - 5
 6 - 10
 over 10
5. Home has
 basement
 slab
 crawl space
 cellar
 water leaks
 mildew
 musty odor
6. If there is a basement
 finished
 unfinished
 carpeted
7. Total number plants
 12 - 24
 over 24
8. Heating system
 forced air
 gravity flow
 stove
 hot water
 floor furnace
 wood burning
9. Air conditioning
 none
 window(s)
 central
10. Air filtering
 none
 furnace filter
 electronic filter
 central
 portable
 HEPA
 central
 portable
11. Use of fans
 none
 floor
 attic
 window
12. Moisture control
 none
 humidifier
 dehumidifier
 vaporizer
 steam
 cool mist
13. Inside home use of
 aerosols
 sprays
 powders
 lacquers
 varnishes
 paints
14. Smokers in home
 none
 one
 two
15. If you smoke
cigarettes per day _____
years smoked _____
stopped in _____
16. Do you have animals in your home?
 dog
 cat
 bird
 rodent
 other _____
Is the animal in the bedroom?
 Yes
 No
Who feeds them? _____
Who cleans them? _____
Had for how long? _____
17. Do you visit other homes with pets?
 No
 Yes - how often? _____
18. Farm crop exposure
 milo
 wheat
 oat
 corn
 soybean
 alfalfa
19. Farm animals:
 horses
 hogs
 cattle
 sheep
 goats
 chickens
 other _____
20. Patient's bedroom
what floor of home: _____
bedding:
 spring
 water
 crib
carpet age: _____ years
21. If patient is child - how often and for how long
 sitters _____
 preschool _____
 day care _____
 kindergarten _____
 grandparents _____
22. Sports participation (please list):

23. Do you believe your occupation causes or aggravates your symptoms?
 No
 Yes (describe) _____

24. Use of latex gloves?
 Yes
 No

