



SOUTHDAL E ALLERGY AND ASTHMA CLINIC

PATIENT'S NAME: _____ **AGE:** _____ **DATE:** _____

What problem brings you to us? _____

Age when first symptom started: _____

Circle your symptoms and state when you observed them the very first time.

Eyes: Itching — Tearing — Redness — Puffy eyelids _____

Nose: Itching — Sneezing — Stuffiness — Drainage _____

Headaches: Dullness — Pressure _____

Ears: Itching — Popping — Fullness — Hearing loss _____

Throat: Irritation — Itching — Hoarseness — Drainage _____

Lungs: Chest tightness — Wheezing — Cough _____

Skin: Eczema — Hives — Rash _____

Others: Fatigue — Stomach cramps — Diarrhea _____

Are you worse at certain times of the year? _____

List the month(s) you feel best: _____

List the month(s) you feel worst: _____

List members of your family who have allergies, sinus disease, hayfever, chronic cough, asthma, skin allergy, migraine, etc. Father: _____

Mother: _____ Children: _____

Circle any of the following you had as a baby or small child.

Eczema — Colic — Problems with formula — Problems with solid food — Frequent colds —

Bronchitis — Earaches. List any others: _____

If you are away from home, are your symptoms worse, better, or unchanged? _____

Last vacation — Where? _____ When? _____

Other vacations or trips away from home: _____

Do you feel different when visiting relative's or friend's homes? _____

Please circle the factors which trigger your symptoms or make them worse.

Sunny weather — Rainy weather — Overcast weather — High humidity — Windy weather —

Cold winter air — Draft of air conditioning — Sudden temperature changes —

Exertion — Infections — Indoors — Outdoors — Natural Christmas tree — House dust —

Mowing the lawn — Raking leaves — Being in a barn or stable — Camping trips —

Cold food — Hot food — Spicy food — Ingestion of beer, wine, or other alcoholic beverages —

Cigarette smoke — Perfumes — Hairspray — Cooking odors — Gasoline fumes —

Exhaust fumes — Other odors — Feather pillow —

Exposure to animals, which ones? _____

Emotions — Medications (for instance Aspirin): _____

Insecticides — Others: _____

Some of the factors listed above may make you feel better. Please list.

Are you worst upon — arising — during daytime — late evening — at night — after meals?

List foods not tolerated and symptoms caused by them. None suspected

Foods

Symptoms

List medications you are allergic to or which cause side effects (for instance Penicillin causing a rash

or hives): Medication

Symptoms

none known

Did you observe adverse reactions to immunizations? _____

Did you have unusual reactions after insect stings (bee stings)? _____

At work or when enjoying hobbies, are you exposed to dust, fumes, chemicals, odors, or animals (farm, pet, or laboratory)? _____

Are your symptoms worse at work? _____

When did you move into your present home? _____ Year built: _____

Are you living in the city or a rural area? _____

Are there any sources of air pollution nearby? _____

Type of house: Frame — Concrete — Brick — Apartment building — Mobile Home

Does your house have a basement? _____

Is it dry, damp, or wet? Does it smell musty? _____

Do you have molds in the basement, bathroom, or on window frames? _____

Heating system: Fuel: Gas — Electric — Fuel oil — Coal

System: Forced air — Gravity — Radiators — Baseboard

Filter: No filter — Fiberglass filter — Electrostatic air cleaner — Other filter

Do you have a fireplace, window air-conditioner, or a central air-conditioner?

Carpeting: Wall to wall? In which rooms? _____

Patient's **bedroom**: Carpeting — Throw rugs

Please list all **bedroom** furniture: _____

Pillow: Feather — Foam rubber — Dacron — Other _____

Comforter — Quilt — Bedspread

Mattress: Cotton — Kapok — Foam rubber — Synthetic — Foam — Other _____

Boxspring: Cotton — Kapok — Foam Rubber — Synthetic — Foam — Other _____

In which room of your home do you feel worst? _____

Who smokes at home? _____

How much do you smoke? _____ If none, when did you quit? _____

What pets do you have in the house? _____

Outside? _____

House plants? How many? In which rooms? _____

