

Sections A, B and C to be completed by patient, Section D to be completed by physician.

(For Physician's Office Use)

Patient Name \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

Physician Name \_\_\_\_\_

Address \_\_\_\_\_

**Section A — Medical Information**

Describe your chief complaint: \_\_\_\_\_

\_\_\_\_\_

Are your symptoms constant or intermittent? \_\_\_\_\_

During what months do you usually have symptoms?

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

During what months are symptoms most severe?

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

How and when did this condition begin? \_\_\_\_\_

\_\_\_\_\_

Check any of the following symptoms you have:

- |   | Now                      | In the Past              |
|---|--------------------------|--------------------------|
| Repetitive sneezing                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic runny nose                        | <input type="checkbox"/> | <input type="checkbox"/> |
| Nasal stuffiness, blockage                | <input type="checkbox"/> | <input type="checkbox"/> |
| Is it intermittent or constant _____      |                          |                          |
| Itching of the nose, eyes, throat or skin | <input type="checkbox"/> | <input type="checkbox"/> |
| Watery eyes                               | <input type="checkbox"/> | <input type="checkbox"/> |
| Recurrent sore throats                    | <input type="checkbox"/> | <input type="checkbox"/> |
| Recurrent ear infections                  | <input type="checkbox"/> | <input type="checkbox"/> |
| Chronic coughing                          | <input type="checkbox"/> | <input type="checkbox"/> |

In the past did you have?

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Eczema                                      | <input type="checkbox"/> | <input type="checkbox"/> |
| Colic                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Milk allergy                                | <input type="checkbox"/> | <input type="checkbox"/> |
| or other food allergy                       | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent upper respiratory tract infections | <input type="checkbox"/> | <input type="checkbox"/> |
| Frequent ear infections                     | <input type="checkbox"/> | <input type="checkbox"/> |

Do any of your blood relatives have asthma, allergy, eczema?

- | Yes                      | No                       |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |

Have you had allergy testing before?

- | Yes                      | No                       |
|--------------------------|--------------------------|
| <input type="checkbox"/> | <input type="checkbox"/> |

Method (skin test, blood test, etc.) \_\_\_\_\_

What were you allergic to? \_\_\_\_\_

\_\_\_\_\_

What symptoms were you having at that time? \_\_\_\_\_

\_\_\_\_\_

Did you take allergy injections? \_\_\_\_\_

\_\_\_\_\_

For what allergens? \_\_\_\_\_

\_\_\_\_\_

How long did you take injections? \_\_\_\_\_

\_\_\_\_\_

Did your symptoms improve? \_\_\_\_\_

\_\_\_\_\_

**What prescription and non-prescription medications do you take?**

- |   |   |   |   |
|---|---|---|---|
| <input type="checkbox"/> Aspirin                        | <input type="checkbox"/> Birth control      | <input type="checkbox"/> Nose drops/sprays                      | List others:<br>_____<br>_____<br>_____ |
| <input type="checkbox"/> Cortisone                      | <input type="checkbox"/> Antibiotics        | <input type="checkbox"/> Hormones                               |   |
| <input type="checkbox"/> Tranquilizers                  | <input type="checkbox"/> Vitamins           | <input type="checkbox"/> Antihistamines                         |   |
| <input type="checkbox"/> High blood pressure medication | <input type="checkbox"/> Ointments          | <input type="checkbox"/> Decongestants                          |   |
| <input type="checkbox"/> Sedatives                      | <input type="checkbox"/> Thyroid medication | <input type="checkbox"/> Anticholesterol drugs (Cholestyramine) |   |

What medications relieve your allergy symptoms? \_\_\_\_\_

**Check the following medical conditions you are experiencing or have experienced in the past:**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High blood pressure           | <input type="checkbox"/> Heart disease      | <input type="checkbox"/> Migraine headache |
| <input type="checkbox"/> Thyroid disfunction           | <input type="checkbox"/> Arthritis          | <input type="checkbox"/> Croup             |
| <input type="checkbox"/> Seizures                      | <input type="checkbox"/> Asthma             | <input type="checkbox"/> Emphysema         |
| <input type="checkbox"/> Bronchitis                    | <input type="checkbox"/> Hay fever          | <input type="checkbox"/> Hives             |
| <input type="checkbox"/> Skin disease                  | <input type="checkbox"/> Drug allergy       | <input type="checkbox"/> Colitis           |
| <input type="checkbox"/> Sinus disease                 | <input type="checkbox"/> Nasal polyps       | <input type="checkbox"/> Broken nose       |
| <input type="checkbox"/> Nasal surgery                 | <input type="checkbox"/> Milk allergy       | <input type="checkbox"/> Ulcers            |
| <input type="checkbox"/> Stomach or intestinal disease | <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Deviated septum   |

**Smoking Habits:**

Cigarettes # \_\_\_\_\_ /day Pipe # \_\_\_\_\_ /day  
Cigars # \_\_\_\_\_ /day Years smoked: \_\_\_\_\_  
Stopped smoking in 19\_\_\_\_\_

**Check the following that apply:**

- |   |                                       |
|---|---------------------------------------|
| <input type="checkbox"/> Family problems                    | <input type="checkbox"/> Over-anxious |
| <input type="checkbox"/> School problems                    | <input type="checkbox"/> Divorced     |
| <input type="checkbox"/> Frequently absent from school/work | <input type="checkbox"/> Separated    |

**List all surgeries and hospitalizations:**

| Date  | Type of Surgery | Reason |
|-------|-----------------|--------|
| _____ | _____           | _____  |
| _____ | _____           | _____  |
| _____ | _____           | _____  |

**List physicians you have consulted in the past 5 years for allergy or other medical problems:**

| Name  | Address/Phone | Reason |
|-------|---------------|--------|
| _____ | _____         | _____  |
| _____ | _____         | _____  |
| _____ | _____         | _____  |

**Section B — Environmental Exposures**

**Home:**  House  Apartment  Condominium  Mobile Home

**Age of home:** \_\_\_\_\_ **How long have you lived there?** \_\_\_\_\_

**Heating system:**  Gas  Oil  Electric  Wood  Coal

Other \_\_\_\_\_

**Method of delivery:**  Forced air  Radiant

**Air Conditioning:**  None  Bedroom  Central

**Electronic Air Cleaners:**  None  Bedroom  Central

**Humidifiers:**  None  Bedroom  Central

**Carpeting:**  None  Bedroom  Living Room  Family Room

**Age of carpet:** \_\_\_\_\_ **Type of material:** \_\_\_\_\_

**Type of padding:** \_\_\_\_\_

**Mattress:**  Cotton  Foam Rubber  Feather  Water Bed

**Age of mattress:** \_\_\_\_\_

**Pillows:**  Dacron  Foam Rubber  Feather

**Age of pillows:** \_\_\_\_\_

- |   | Yes                      | No                       |
|---|--------------------------|--------------------------|
| Do you use a down comforter on the bed?     | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have stuffed animals in the bedroom? | <input type="checkbox"/> | <input type="checkbox"/> |
| Do you have books stored in the bedroom?    | <input type="checkbox"/> | <input type="checkbox"/> |

**List pets currently in the home:** \_\_\_\_\_  
\_\_\_\_\_

**How long have you had pets?** \_\_\_\_\_

**Does anyone smoke at home?**  Yes  No

Is there mold or mildew in the home? Yes No

Do you have houseplants? Yes No

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

List your hobbies: \_\_\_\_\_

- Check any of the following that cause or aggravate your symptoms:**
- |   |  |  |  |  |
|---|--|--|--|--|
| <input type="checkbox"/> In-doors         | <input type="checkbox"/> In barns          | <input type="checkbox"/> Insecticides        | <input type="checkbox"/> Milk or milk products | <input type="checkbox"/> Alcoholic beverages |
| <input type="checkbox"/> Out-doors        | <input type="checkbox"/> Damp areas        | <input type="checkbox"/> Paint fumes         | <input type="checkbox"/> Eggs                  | <input type="checkbox"/> Beer                |
| <input type="checkbox"/> Weather change   | <input type="checkbox"/> Hay, circus       | <input type="checkbox"/> Perfumes            | <input type="checkbox"/> Wheat products        | <input type="checkbox"/> Wine                |
| <input type="checkbox"/> Wet weather      | <input type="checkbox"/> Mowing lawn       | <input type="checkbox"/> Cosmetics           | <input type="checkbox"/> Nuts, beans or seeds  | <input type="checkbox"/> Cheese              |
| <input type="checkbox"/> Dry weather      | <input type="checkbox"/> Dusty environment | <input type="checkbox"/> Permanent wave sets | <input type="checkbox"/> Chocolate             | <input type="checkbox"/> Mushrooms           |
| <input type="checkbox"/> Windy day        | <input type="checkbox"/> Animals           | <input type="checkbox"/> Newspapers          | <input type="checkbox"/> Fish                  | <input type="checkbox"/> Aspirin             |
| <input type="checkbox"/> Hot day          | <input type="checkbox"/> Cooking odors     | <input type="checkbox"/> Wool                | <input type="checkbox"/> Meat                  | <input type="checkbox"/> Other (list) _____  |
| <input type="checkbox"/> Cold day         | <input type="checkbox"/> Smoke             | <input type="checkbox"/> Road dust           | <input type="checkbox"/> Fruit                 | _____  |
| <input type="checkbox"/> Air conditioning | <input type="checkbox"/> Soap powder       | <input type="checkbox"/> High pollution day  | <input type="checkbox"/> Vegetables            | _____  |

**Section C -- Dietary Habits**

How often do you eat the following foods?

|                 |                  |               |                   |           |
|-----------------|------------------|---------------|-------------------|-----------|
| 0 = never       | 1 = once weekly  | 2 = 3x a week | 3 = 5x a week     | 4 = daily |
| _____ Milk      | _____ Egg        | _____ Bread   | _____ Lettuce     |           |
| _____ Cheese    | _____ Chicken    | _____ Cereals | _____ Chocolate   |           |
| _____ Ice cream | _____ Turkey     | _____ Rice    | _____ Peanuts     |           |
| _____ Yogurt    | _____ Fish       | _____ Corn    | _____ Cola drinks |           |
| _____ Beef      | _____ Orange     | _____ Tomato  | _____ Grape       |           |
| _____ Pork      | _____ Grapefruit | _____ Potato  | _____ Apple       |           |

How many cups of coffee or tea daily? \_\_\_\_\_

What kind of alcoholic beverages do you drink? \_\_\_\_\_  
 how often? \_\_\_\_\_

Do you use any nutritional powders or supplements like an instant breakfast? \_\_\_\_\_

List other food you eat 5x a week or more: \_\_\_\_\_

List any daily vitamin or mineral supplements: \_\_\_\_\_

Are you following a special diet at this time? \_\_\_\_\_

**Section D -- Systems Review**

To be completed by the Physician after reviewing the Patient's Answers in Section A, B and C.

This outline is meant to be a guide for recognition of the possible cause and effect with inhalants, foods, drugs, and chemicals. It does not mean that all symptoms listed below are manifestations of allergy.

- A. Head and Neck**
- Headache
  - Migraine
  - Vascular
  - Histamine
- B. Ophthalmic**
- Allergic conjunctivitis
  - Allergic shiners
  - Periorbital edema
  - Photophobia
  - Episodic blurring of vision
  - Transient refractive changes
- C. Otologic**
- Serious otitis
  - Ear popping
  - Tinnitus
  - Hearing loss
  - Meniere's syndrome
  - Vertigo
  - Fissured ears

**D. Respiratory**

- Allergic rhinitis
- Allergic tracheitis
- Allergic laryngitis
- Allergic bronchitis
- Cough
- Wheeze
- Dyspnea
- Asthma
- Nasal speech
- Nasal crease
- Allergic salute
- Laryngeal edema — hoarseness
- Postnasal discharge
- Frequent nosebleeds
- Polyps
- Sinusitis

**E. Cardiovascular**

- Tachycardia
- Palpitation
- Arrhythmia
- Chilling — flushing
- Edema — localized
- Edema — generalized
- Vasoconstriction — dilation
- Ecchymosis
- Vasculitis
- EKG changes
- Anginal pain

**F. Gastrointestinal**

- Aphthous stomatitis
- Colic — cramps
- Foul odor to the breath
- Difficult swallowing
- Lump in throat
- Nausea
- Bloating
- Vomiting
- Indigestion
- Retasting of food
- Gas — belching — stomachache
- Abdominal pain
- Abdominal distention
- Pruritus ani — pain — fissure
- Mucous colitis
- Constipation — diarrhea
- Ulcer syndrome
- Gallbladder syndrome
- Appendiceal syndrome
- Ulcerative colitis syndrome

**G. Dermatologic**

- Urticaria
- Atopic dermatitis
- Adult acne
- Hand dermatitis
- Pallor

**H. Muscular — Skeletal**

- Muscle aches
- Arthralgia
- Edema of joints
- Myalgia — leg aches — restless legs
- Rheumatoid syndrome
- Undue fatigue — sluggishness

**I. Central Nervous System**

- Excessive drowsiness
- Episodic dullness or dreaminess
- Tension-fatigue syndrome
- Irritability
- Insomnia
- Hyperactivity
- Learning disability

**J. Psychiatric**

- Aggressiveness
- Inability to concentrate
- Personality changes

**K. Genitourinary**

- Frequency — urgency
- Dysuria
- Enuresis
- Albuminuria — hematuria
- Prostatic edema
- Vaginitis — itching
- Nocturia

**L. Hematologic**

- Anemia
- Neutropenia
- Thrombocytopenia — purpura
- Leukopenia
- Eosinophilia



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