Date: _____

Patient's Name : _____

Referring Physician: _____

Chief Complaints: (check your main symptoms, those that prompted your visit)

HEAD OR NOSE SYMPTOMS

Sneezing _____
nose blocking _____
runny nose _____
postnasal drain _____
sinus infection _____
sore throat _____
ear blocking _____
headaches _____
eye symptoms _____

SKIN SYMPTOMS

hives _____
eczema _____
itching _____
swelling _____

CHEST SYMPTOMS

cough _____
wheezing _____
shortness of breath _____
chest infection _____
hoarseness or
loss of voice _____

INSECT STINGS

hives-swelling _____
shortness of breath _____
wheeze _____
dizziness _____
passing out _____

OTHER (please explain in a few words): _____

_____

_____

1. Approximately how many years have you suffered from the chief complaints of:
   Head or nose symptoms _____ Chest symptoms _____ Skin symptoms _____
   Insect sting reaction _____ Other _____

Please note: This information may be important for your insurance coverage, especially in a patient who has recently obtained new insurance.

2. If you have respiratory symptoms indicate their pattern:

	HEAD/NOSE	**CHEST**
Year round, no season variation	_____	_____
Year round, worse seasonally	_____	_____
Seasonally only	_____	_____

If seasonal list months _____

3. How may days of school or work have you missed in the past because of these symptoms? _____
   How may times have you required ER or Doctor visits for ACUTE symptoms in the past 12 months? _____
   How many times have you required overnight hospitalization related to the above symptoms? _____

FOR CHILDREN ONLY

A. Estimate the number of fuzzy stuffed toys in the bedroom. _____
B. Attends: ___ day care / ___ school? No _____ Yes _____Number of days per week _____
C. Does any member(s) in the household smoke? Yes _____ No _____
   If so, whom? _____
D. Are any symptoms worse: Indoors _____ Outdoors _____ No difference _____
   Note any specific location or activity known to provoke symptoms: _____

_____

TURN OVER FOR PAGE 2

ENVIRONMENTAL SURVEY

Residence: House _____ Mobile Home _____ Apartment _____

Bedroom floors: Wall to wall carpet _____ Wood _____ Linoleum _____

Living/den/family room floors: Wall to wall carpet _____ Wood _____ Linoleum _____

Wallpaper in bathrooms: Yes _____ No _____

Type of heat: Electric _____ Gas _____ Space _____ Oil/kerosene _____

Air conditioning: Central _____ Window unit _____ Fans _____

1. Do you frequently use ceiling fans? Yes _____ No _____
2. Any mold or mildew noted growing in or around the house? Yes _____ No _____
   If so, where? _____
3. Any history of carpet being soaked (leaky roof, burst pipe, etc.)? Yes _____ No _____
   If so, when/where? _____

4. Do you have any pets at home? Yes _____ No _____If so, what kind? _____
   Outside completely_____ Outside some, inside some _____ Inside mostly _____
5. Do you use: scented candles _____ potpourri _____ plug in air fresheners _____

6. Do you note increased symptoms from any of the following:

ALLERGENS	**IRRITANTS**	**WEATHER**	**INGESTANTS**
Mowed grass _____	perfumes _____	windy days _____	Alcoholic beverages _____
House dust _____	soaps _____	cold fronts _____	Drugs _____
Dead grass _____	smoke _____	temp. change _____	Foods _____
Dead leaves _____	paint _____	damp weather _____	Please list any specific ingestants:
Cats _____	detergents ____		_____
Dogs _____	hair spray _____		_____
Hay _____	outside dust ____		_____
Feathers _____			

7. Do you use nose drops or sprays? Yes _____ No _____
   If so, how often? Occasionally _____ Regularly _____

8. Have you taken hyposensitization shots (allergy shots) previously? Yes _____ No _____
   Are you still taking them? Yes _____ No _____

9. How long has it been since you have had a CHEST X-ray? _____
   How long has it been since you have had a SINUS X-ray? _____

10. At your workplace, are you exposed to allergens or irritants? Yes _____ No _____
    If yes, briefly explain: _____
    _____

11. Do you have any hobbies or past times that expose you to allergens or irritants? Yes _____ No _____
    If yes, briefly explain: _____