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NAME: _____
 DATE: _____ PT ID#: _____
 HOME #: _____ WORK #: _____
 CELL #: _____
 AGE: _____ AGE AT WHICH SYMPTOMS BEGAN: _____

SYMPTOMS: List your top three symptoms starting with the most bothersome.

1. _____ 2. _____ 3. _____

FREQUENCY/TIME OF SYMPTOMS:

_____ Sporadic (at various times of year but with no pattern)
 _____ Persistent (throughout the year)
 _____ Seasonal (indicate the prominent months below)

Do you smoke? Yes No

Are you around 2nd hand smoke? Yes No

Do you drink alcohol? Yes No

If Yes, number of drinks per week? _____

SURROUNDINGS: Indicate where/when symptoms occur: (Example: Mowing, Basement, At work, Weather changes)

PETS: (Indicate animals you are frequently exposed to)

Dog Rabbit Bird Other _____
 Cat Horse Hamster

PREVIOUS ALLERGY TESTING:

Method: Skin Test
 Blood Test

Have you ever been tested for allergies? Yes No

If Yes: When: _____ Where: _____

MEDICAL HISTORY: (Check if you now have or have ever been diagnosed with)

<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Severe allergic reaction
<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression	<input type="checkbox"/> Psychiatric disorders
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Cancer	<input type="checkbox"/> Sleeping disorders
<input type="checkbox"/> Kidney or Liver problems	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraines	_____

***Women:** Are you pregnant now or think you may be? Yes No

LIST ALL MEDICATIONS THAT YOU CURRENTLY TAKE:

(Including over-the-counter and herbal supplements)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____
 (Patient or Guardian)

Date: _____