



Cincinnati Allergy & Asthma Center

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INSTRUCTIONS: Please answer the questions on this form as they relate to the person being evaluated. Please bring the completed forms to our office for your first appointment.

Patient's Name: _____ Sex: _____ Age: _____ Date of Birth: _____

Referred by: _____ Primary Dr: _____

Do any of your relatives come here? Names: _____

I. BRIEFLY DESCRIBE the reason for your allergy visit and what you hope to accomplish: _____

II. SYMPTOMS: Check each box that applies to the symptoms you experience

<input checked="" type="checkbox"/> NOSE:	<input checked="" type="checkbox"/> SINUS:	<input checked="" type="checkbox"/> CHEST:	<input checked="" type="checkbox"/> SKIN:
Stuffy nose	Headaches	Tightness	Rash
Sneezing	Sore throats	Wheezing	Hives
Itchy	Post-nasal-drainage	Wheezing when exposed to:	Eczema
Clear/colorless discharge	Throat clearing		Swelling
Thick/colored discharge	Sniffles	Wheezing with colds/infections	Itching
Mouth breathing/snoring	Hoarseness	Wheezing/cough after exercise	Sores
Loss/decreased sense of smell	Bad breath	Shortness-of-breath	<input checked="" type="checkbox"/> OTHER:
Nose bleeds	Frequent sinus infections	Productive cough	Fatigue
<input checked="" type="checkbox"/> EYES:	<input checked="" type="checkbox"/> EARS:	Dry Cough	
Red	Itchy	Bronchitis	
Itchy	Fullness/popping		
Watery	Painful		
Dark circles	Ringing/hearing loss		
Puffiness	Frequent ear infections		

III. TRIGGERS OF YOUR SYMPTOMS: Are your symptoms: Year-round Seasonal Both Not sure

During what months do you usually have symptoms? Jan Feb Mar Apr May June July Aug Sept Oct Nov Dec

Which of the following cause your symptoms or make them worse? Check each box that applies.

Mowing lawn/yard work	Weather change	Smoke	Alcohol
Vacuuming/house dust	Wet weather	Cleaning agents	Beer
Cedar	Dry weather	Newspaper	Wine
Pollen	Windy day	Indoors	Stress
Mold or mildew	Hot day	Outdoors	Other:
Damp areas	Cold day	At home	
Dogs	Air-conditioning	At work	
Cats	Air pollution	Morning	
Other animals:	Perfume	Afternoon	
	Chemical fumes	Night	

-----** Staff only – Do not write below this line ** -----

Clinical Summary: _____

IV. DURATION/SEVERITY OF SYMPTOMS:

Have your symptoms been present: all your life _____ months _____ years
 Are your symptoms: Mild Moderate Severe Rare Frequent
 Constant Interfering with life Preventing normal activities

V. FOOD REACTIONS: Have you ever had any *systemic symptoms* after ingestion of food or liquid? Yes No
 Itching Hives Wheezing Shortness-of-breath Throat swelling Dizziness Swelling Shock
 Specify food/liquid causing reaction, details, and how many episodes: _____

Do you have any of these *significant* intestinal symptoms after ingestion of food or liquid? Yes No
 Nausea Vomiting Cramps Pain Diarrhea Other
 Specify food/liquid causing reaction, details, and how many episodes: _____

VI. INSECT STING REACTIONS: Have you ever had any *systemic symptoms* after a sting? Yes No
 Hives Wheezing Shortness-of-breath Throat swelling Fainting Dizziness
 Specify insect (bee, wasp, etc) causing reaction, details, and how many episodes: _____

VII. MEDICATIONS:

Please list ALL PRESENT medications:	Dose:	Date Started	List ALL PREVIOUS allergy/asthma medications:
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Have you used nasal sprays? Yes No If yes, name: _____
 Have you taken cortisone (steroids)? Yes No If yes, when: _____

Medication reactions: List any medication allergy or reaction below.

Medication allergies:	Approximate Date:	Symptoms:
1.		
2.		
3.		
4.		
5.		

Have you ever had a reaction to X-ray dye? Yes No If yes, specify: _____

IX. PREVIOUS ALLERGY EVALUATION:

Have you seen an allergist? Yes No If yes, allergist's name: _____
 Have you had allergy skin testing? Yes No If yes:
 • Date tested: _____ Positive Negative
 • Positive to: _____
 Have you received allergy injections: Yes No If yes:
 • Help symptoms? Yes No
 • Adverse reactions? Yes No Specify: _____

X. HOME ENVIRONMENT:

Do you live in a: House Apt Condo Mobile home Single Two story
 How long have you lived there? _____ years _____ months Age of home: _____ years
 Is it located on/near: water vacant land industrial area farm
 Air conditioning: central window unit none Ceiling fans: Yes No
 Type of heat: electric gas oil steam/forced air kerosene wood burning stove fireplace

Type of flooring (check box):

Type of flooring:	<input checked="" type="checkbox"/> Carpet	<input checked="" type="checkbox"/> Wood	<input checked="" type="checkbox"/> Tile	<input checked="" type="checkbox"/> Vinyl	<input checked="" type="checkbox"/> Other
Bedroom					
Living area					

How old is your mattress? _____ Type of mattress: inner spring water allergy encasing
 How old is your pillow? _____ Type of pillow: feather synthetic foam allergy encasing
PETS: Do you have any pets? Yes No If yes, list the number and kind (ie, dogs, cats, birds, etc).

- Symptoms of allergy/asthma worse around your pets? Yes No
- Pets live: Indoors Outdoors Both
- Pets sleep in bedroom: Yes No
- Pets sleep on your bed: Yes No

XI. WORK ENVIRONMENT:

Where are you employed? _____ Occupation? _____
 How long? _____ Years _____ months Is your environment: carpeted tiled other
 Is it air conditioned? Yes No Is smoking permitted? Yes No
 Are you exposed to chemicals or strong odors? Yes No Specify _____
 Are your symptoms worse at work? Yes No Specify _____
 Have you missed time from work due to an illness? Yes No Specify _____
 Days missed: _____

XII. SCHOOL HISTORY/ENVIRONMENT:

Do you attend school? Yes No What grade level? _____
 Is your classroom: carpeted tiled other
 Animals in your classroom? Yes No
 Do you participate in physical education? Yes No
 Have you missed time from school due to an illness? Yes No Specify _____
 Days missed: _____

XIII. PAST MEDICAL HISTORY: Please list any surgeries/hospitalizations/medical conditions/ER visits below.

ER VISITS AND/OR HOSPITALIZATIONS	DATE	SURGERIES	DATE	MEDICAL CONDITIONS	DATE

CHILD BIRTH: Yes No If yes, date(s): _____

XIV. SYSTEMS REVIEW: Do you have recurrent or chronic problems with any of the following?

- | | | |
|---|--|---|
| <input type="checkbox"/> Frequent headaches | <input type="checkbox"/> Chest pain | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Vision disturbance | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Wear glasses | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Wear contacts: soft / gas perm | <input type="checkbox"/> Rapid heart beat | <input type="checkbox"/> Frequent/painful urination |
| <input type="checkbox"/> Frequent colds (_____ a year) | <input type="checkbox"/> Nausea/vomiting | <input type="checkbox"/> Arthritis |

List any other chronic symptoms: _____

What is your weight now? _____ What was your weight 1-year-ago? _____

When was your last chest x-ray? _____ Results: _____

Have you had sinus x-rays? Yes No Results: _____

XV. SOCIAL:

Where were you born? _____ Raised? _____

Where have you lived? _____

When did you move to this area? _____

Are you: Married Single Widowed Divorced

What was the last grade of school you completed? _____

How many children do you have? _____ Ages: _____

Do you exercise? Yes No How often: _____

Do you drink alcohol? Yes No How often: _____ How much: _____

XVI. SMOKING:

Do you presently smoke? Yes No If yes, average number of cigarettes per day: _____

How long have you been smoking? _____

Have you ever smoked? Yes No If yes, average number of cigarettes per day: _____

How long did you smoke? _____ When did you stop? _____

Does anyone smoke in your home? Yes No Who? _____

XVII. FAMILY HISTORY: List family members who have a history of any of the following illnesses (check box).

<input checked="" type="checkbox"/>	ILLNESS	FAMILY MEMBER	<input checked="" type="checkbox"/>	ILLNESS	FAMILY MEMBER
<input type="checkbox"/>	Hay fever		<input type="checkbox"/>	Headaches	
<input type="checkbox"/>	Asthma		<input type="checkbox"/>	Cancer	
<input type="checkbox"/>	Eczema		<input type="checkbox"/>	Diabetes	
<input type="checkbox"/>	Hives		<input type="checkbox"/>	High blood pressure	
<input type="checkbox"/>	Swelling		<input type="checkbox"/>	Heart attack	
<input type="checkbox"/>	Food allergy		<input type="checkbox"/>	Other	

If a patient is a child – please complete the following:

- Place of birth: _____ Age of mother: _____
- Pregnancy / labor / delivery normal? Yes No Specify: _____
- Birth weight: _____
- Eating: Formula Breast-fed Well tolerated: Yes No
- Has child reached normal growth milestones? Yes No Specify: _____
- Your relationship to child: _____

Date: _____ Signature of patient/guardian: _____