**ALLERGY PATIENTS ONLY**  DATE:

CHART #

NAME: DATE OF BIRTH:

**What bothers you the most?**

**When your problems are at their WORST, how much trouble do you have with**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | **None** | **Mild** | **Moderate** | **Severe** |  |
| Nasal congestion and fullness |  |  |  |  |
| Nasal blockage or mouth breathing |  |  |  |  |
| Drainage out the front of the nose |  |  |  |  |
| Drainage down the throat |  |  |  |  |
| Itching in the throat |  |  |  |  |
| Itching/Watering Eyes |  |  |  |  |
| Sneezing |  |  |  |  |
| Cough |  |  |  |  |
| Shortness of Breath |  |  |  |  |
| Wheezing |  |  |  |  |
| Facial pain |  |  |  |  |  |
| Headaches |  |  |  |  |  |
| Eczema |  |  |  |  |  |

How long have you had these symptoms? Are they: Constant Come and Go

Symptoms are triggered by

Symptoms are WORST in WINTER SPRING SUMMER FALL NO SEASONAL PATTERN

Have you ever been tested for allergies? YES NO Date of last test?

Name and location of doctor who tested you

Have you been on allergy shots? YES NO From to

Did the previous allergy shots help your symptoms? YES SOME NO

Have you taken an antihistamine? YES NO Date last taken? Did they help?

Circle all tried: Zyrtec Xyzal Allegra Claritin Loratadine Fexofenadine Benadryl

Have you ever taken a nasal steroid? YES NO Date last taken? Did they help?

Circle all tried: Flonase Nasocort Nasonex Rhinocort Veramyst Omnaris

Have you been treated with steroids for allergies or asthma? YES NO PILLS or INJECTION

(Examples: prednisone, medrol dose pack, “sinus cocktail”) Did they help?

How often are you on antibiotics for your symptoms? Do antibiotics help?

Any other allergy treatments?

List any animals with which you have contact.

DATE:

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E-Mail Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |  |
| --- | --- | --- | --- |
| **List your allergies to medicines**   * No drug allergies * Penicillin * Sulfa * Codeine * Anesthetics * Other – List Below | **Race / Ethnicity**   * White * African-American * Hispanic * American Indian * European * Asian * Other   **Preferred Language**   * English * Spanish * Other | **Do you take any medications?**  YES NO  **Please list them below.** | **Do you have the following?**    Diabetes YES NO  Hypertension YES NO  Heart Disease YES NO  **List any other medical conditions.** |
| **Does any blood relative have:**   * Bleeding tendency * Allergy problems * Diabetes * Hepatitis B * Hearing loss * Heart disease | **Social History**  Alcohol \_\_\_\_\_\_\_\_\_\_ oz / day    Smoke? No Yes Former  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ packs/day  Smokeless tobacco?  Do you have second hand smoke  Exposure? If yes, please circle    Home Work Social | **May we contact your pharmacy to get your medication history?**  YES NO  **Preferred Pharmacy:** | **List any surgeries you have had.**   * NONE |

I authorize and consent to my blood being tested for communicable diseases **if any person is exposed** to my blood or other bodily fluids at the ENT and Allergy Center. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS (please circle if present)

**Constitutional**: Night Sweats Fatigue Weight Loss

**Eyes**: Blurred Vision Double Vision Eye Pain

**Heart**: Chest Pain Heart Palpitations Swelling in Legs

**Lungs**: Cough Spitting up Blood Shortness of Breath

**GI**: Nausea Acid Reflux Difficulty Swallowing

**Bone/Joint**: Joint Pain Joint Swelling Muscle Cramps or Weakness

**Skin**: Rash Skin Cancer

**Psychiatric**: Anxiety Depression

**Hematology**: Easy Bruising Blood Clots Lymph Node Enlargement

**Allergy**: Sneezing Itching/Watery Eyes