

Allergy & Asthma Consultants, L.L.P.
800 W.34th Street • Suite 201 • Austin, Texas 78705
Office (512) 454-5821 • Fax (512) 459-9137

Date: _____ **Print Name:** _____

Referring Physician: _____

Reason for Visit: _____

Check Symptoms You Have or Have Had:

Nasal Symptoms

- Frequent sneezing
- Runny nose
- Nasal congestion
- Nose bleeds
- Loss of smell
- Nasal polyps

Sinus Symptoms

- Frequent infections
- Pressure in cheeks
- Pressure around eyes
- Post nasal drip
- Prior sinus surgery

Eye Symptoms

- Itching
- Burning
- Redness
- Swelling of eyelids
- Matting

Ear Symptoms

- Pain
- Itching
- Plugging
- Loss of hearing
- Ringing

Are Your Symptoms Worse:

- At home
- At work
- Out doors
- Around smoke
- Around fumes

Respiratory Symptoms

- Asthma
- Wheezing
- Coughing
- Productive cough
- Dry cough
- Night-time cough
- Exercise-induced wheezing
- Exercise-induced cough
- Chest tightness
- Anything relieve the chest tightness? _____
- Aspirin worsen asthma

Abdominal Symptoms

- Weight loss
 - Heartburn or reflux
 - Frequent diarrhea
 - Known food allergies
- List: _____

Skin Complaints

- Childhood eczema
- Hives
- Contact rash
- Itching

Headache Pains

- Sinus
- Migraine
- Tension
- Associated with menses

Location

- Frontal
 - Temporal Area
- Other site: _____

Frequency

- Daily
- Occasionally
- Seldom

Other Serious Infections

- Ear infections
- Pneumonia
- Skin
- Meningitis

Stinging Insect Reactions

- Large local reactions
 - Anaphylaxis
- Type of insect: _____

- With any activity

List: _____

Allergy & Asthma Consultants, L.L.P.
 800 W.34th Street • Suite 201 • Austin, Texas 78705
 Office (512) 454-5821 • Fax (512) 459-9137

Environmental and Social History:

What is your occupation? _____
 What type of home do you live in? Single-family home: Apartment: Farm or ranch:
 Do you have carpets in the bedrooms? Yes No
 Do you have feather pillows? Yes No
 Do you exercise regularly? Daily: Occasionally:
 Type of exercise: _____

Exposure History:

Any unusual work exposures: _____
 Any unusual hobbies or sports: _____
 Do you have any pets? Dogs _____ Cats _____ Other _____
 Do the pets live indoors? Yes No
 Do the pets sleep in the bedroom? Yes No
 Does exposure to any pets increase your symptoms? Yes No

Medical History:

Primary Care Physician: _____
 Have you ever had previous allergy testing? Yes No
 If so, when? _____
 Have you seen an ear, nose, and throat (ENT) physician? Yes No
 Have you had an adenoidectomy? Yes No
 Have you had a tonsillectomy? Yes No
 Any history of injury to your face or nose? Yes No
 Have you had any other surgeries? Yes No
 Please list: _____
 Have you had a recent chest x-ray? Yes No
 Date: _____
 Have you had a recent sinus CAT scan or x-ray? Yes No
 Date: _____
 Do you smoke? Yes No
 If so, how many packs: _____
 Have you ever smoked? Yes No
 If so, how long did you smoke: _____

Medication History:

Present medications (please list medicine and dose if possible):

Any known medication allergies? Yes No
 If so, please list with reaction: _____

Family History:

	Grand-Parents	Father	Mother	Brother	Sister	Children
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Insect Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chronic Obstructive Pulmonary Disease (COPD)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>