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NAME
AGE
SEX
PATIENT NO.

DO YOU HAVE ALLERGIES?
☐ Yes
☐ No
☐ Don't know

What are you allergic to?

DO ANY OF YOUR BLOOD RELATIVES HAVE ALLERGIES?
☐ Yes
☐ No
☐ Don't know

NAME
BY
DATE

WHAT MEDICATIONS DO YOU TAKE DAILY OR FREQUENTLY?

| | | | |
|---|---|---|---|
| ☐ | Aspirin | ☐ | Vitamins |
| ☐ | Cortisone | ☐ | Ointments |
| ☐ | Laxatives | ☐ | Nose Drops |
| ☐ | Sedatives | ☐ | Hormones |
| ☐ | Birth Control pills | | |
| ☐ | Other (list): | | |

CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE OR HAD:

☐ High blood pressure
☐ Heart disease
☐ Stomach or intestinal disease
☐ Overactive thyroid
☐ Underactive thyroid
☐ Any hormonal difficulty
☐ Migraine headache
☐ Frequent headaches
☐ Asthma
☐ Emphysema
☐ Bronchitis
☐ Hay fever
☐ Hives
☐ Skin disease
☐ Drug allergy
What drugs?
☐ Other Conditions
☐ Sinus disease
☐ Nasal polyps
☐ Broken nose
☐ Nasal surgery
☐ Deviated septum
☐ Food allergy

DO YOU USE MEDICATION REGULARLY FOR NASAL SYMPTOMS?
☐ Yes
☐ No
What is it?

Does it help?

NOTES

HEATING SYSTEM
☐ None
☐ Oil
☐ Gas
☐ Coal
☐ Electricity
☐ Don't know
☐ Other

METHOD OF HEAT DELIVERY
☐ Hot air blower
☐ Radiators
☐ Electric panels
☐ Don't know

PILLOW:
☐ None used
☐ Foam rubber
☐ Feather
☐ Dacron
☐ Don't know
☐ Other

MATTRESS:
☐ Cotton
☐ Foam rubber
☐ Horse hair
☐ Feather
☐ Don't know
☐ Other

DO YOU USE HUMIDIFIERS?
☐ Yes ☐ No

CHECK SYMPTOMS YOU USUALLY HAVE:

☐ Itching of nose
☐ Stuffy nose
☐ Nose running
☐ Sneezing
☐ Post-nasal drip
☐ Loss of smell
☐ Eyes itch
☐ Eyes water
☐ Throat itch
☐ Ear infection
☐ Sore throat
☐ Cough
☐ Wheeze

HOME:
☐ House ☐ City
☐ Apt ☐ County

YOUR ENVIRONMENT:
OCCUPATION:
Prominent materials used:

At work, are your symptoms:
☐ better ☐ worse ☐ same

AIR CONDITIONING:
☐ Bedroom ☐ At work
☐ Central ☐ None

ANIMALS IN HOME:

| In past | | At present | |
|---|---|---|---|
| ☐ | Dog | ☐ | Dog |
| ☐ | Cat | ☐ | Cat |
| ☐ | Bird | ☐ | Bird |
| ☐ | Rodent | ☐ | Rodent |
| ☐ | Other | ☐ | Other |

Other animals you frequently contact:

ARE SYMPTOMS:
☐ Constant
☐ Erratic
☐ Present most of the time
☐ Present part of the time
☐ Present rarely

DURING WHAT MONTHS DO YOU USUALLY HAVE SYMPTOMS?
☐ All months
☐ Jan ☐ July
☐ Feb ☐ Aug
☐ Mar ☐ Sept
☐ Apr ☐ Oct
☐ May ☐ Nov
☐ June ☐ Dec

ARE SYMPTOMS WORSE:
☐ Morning
☐ Afternoon
☐ Evening
☐ Night
☐ At home
☐ At work
☐ Other location

SMOKING HABITS:
Cigarettes # _____ /day
Pipe # _____ /day
Cigars # _____ /day
Years Smoked _____
Stopped smoking in _____

ARE YOUR SYMPTOMS
☐ Slight
☐ Moderate
☐ Severe

DO YOUR SYMPTOMS INTERFERE WITH YOUR LIFE?
☐ not at all
☐ a little
☐ moderately
☐ prevent many normal activities

SOME OF THE FOLLOWING MAY CAUSE YOUR SYMPTOMS OR MAKE THEM WORSE. CHECK THOSE THAT DO.

☐ indoors
☐ outdoors
☐ Weather change
☐ Wet weather
☐ Dry weather
☐ Windy day
☐ Hot day
☐ Cold day
☐ Air conditioning
☐ In barns
☐ Damp areas
☐ Hay, circus
☐ Mowing lawns
☐ Dusty environments
☐ High pollution day
☐ animals
☐ cooking odors
☐ smoke
☐ soap powder
☐ insecticides
☐ paint fumes
☐ perfumes
☐ cosmetics
☐ wave sets
☐ newspapers
☐ wool
☐ road dust
☐ chemicals (list)
☐ milk or milk products
☐ eggs
☐ wheat products
☐ nuts, beans, or seeds
☐ chocolate
☐ fish
☐ meat
☐ fruit
☐ vegetables
☐ alcoholic beverages
☐ beer
☐ wine
☐ cheese, mushrooms
☐ aspirin
☐ drugs (list)

ACTIVITIES IN WHICH YOU SPEND A GREAT DEAL OF TIME:

☐ Photography ☐ Gardening ☐ Camping ☐ Cooking

☐ Carpentry ☐ Painting ☐ Sewing ☐ Movies

☐ Hobbies (list) ☐ Other (list) ☐ Sports (list)

Describe in your own words what bothers you the most:

Can you remember how the condition began and when?

USE THIS SPACE IF YOU WISH TO AMPLIFY ANY OF ABOVE ANSWERS.

FAMILY HISTORY:

ASTHMA -

URTICARIA -

HAY FEVER -

ECZEMA -

HEADACHES (MIGRAINES) -

OTHER:

PHYSICAL FINDINGS