LIVE OAK ALLERGY & ASTHMA CLINIC

PATIENT NAME:		**AGE:**		**DATE:**	
REFERRED BY:		**MEDS:**			

CHECK (√) SYMPTOMS YOU HAVE HAD PAST OR PRESENT

ALLERGY				***ASTHMA***	
NASAL		BROKEN NOSE		TROUBLE BREATHING	
SINUS		ITCHY EYES		WHEEZING	
STUFFY NOSE		ITCHY NOSE		CHEST TIGHTNESS	
WATERY NOSE		ITCHY EARS		FREQUENT COUGH	
SNEEZING		ITCHY PALATE		BRONCHITIS	
WATERY EYES		LOSS OF SMELL		ASTHMA	
PUFFY/SWOLLEN EYES		LOSS OF TASTE		PNEUMONIA	
FREQUENT HEADACHES		EAR INFECTIONS		NASAL POLYPS	
POST NASAL DRAINAGE		SINUSITIS		FREQUENT RAW THROAT	

DO YOU RELATE ANY OF THE FOLLOWING TO YOUR NASAL (N) OR CHEST (C) PROBLEMS? MARK ("N") OR ("C")

SPRING		BRIGHT SUN		ANIMALS	
SUMMER		FOODS		GRASS	
FALL		SMOKE		WEEDS	
WINTER		DUST		FLOWERS	
WEATHER CHANGES		PERFUMES OR POWDERS		EXERCISE	
DAMPNESS		COSMETICS (which ones):		LAUGHING	
CHILLING		ANGER		COUGHING	

WHEN DID SYMPTOMS BEGIN?	CHEST:		NASAL:				
HAS IT EVER LIMITED ACTIVITY:	AT WORK?	☐ YES ☐ NO	AT SCHOOL?	☐ YES ☐ NO	AT HOME?	☐ YES ☐ NO	
HAVE YOU LOST TIME AT WORK OR SCHOOL DUE TO ILLNESS?	☐ YES ☐ NO	WHEN?					
HAVE YOU EVER BEEN SKIN TESTED BEFORE?	☐ YES ☐ NO	WHEN?		WHAT WERE YOU ALLERGIC TO?			
WERE YOU ON ALLERGY SHOTS?	☐ YES ☐ NO	WHEN?					
HAVE YOU EVER HAD HIVES ("WELTS")?	☐ YES ☐ NO	WHEN?		FROM WHAT?		HOW OFTEN?	

DO YOU HAVE ANY PROBLEMS WITH ANY OF THE FOLLOWING? (PLEASE DESCRIBE)

MEDICINES		OTHERS		FOODS (WHICH ONES?)			
CONTACTANTS?		POISON OAK/ IVY?		METALS?			
DYES?		INSECT STINGS OR BITES?		ANTS?		BEES?	
DO YOU SMOKE?	☐ YES ☐ NO	HOW MANY CIGARETTES/PACKS PER DAY?					
HAVE YOU HAD ANY SERIOUS ILLNESSES?							

DOES ANYONE IN YOUR FAMILY HAVE ANY ALLERGIES? ***(PLEASE CHECK APPROPRIATE BOX)***

	HAY FEVER	**ASTHMA**	**HIVES**	**SINUSITIS**
MOTHER				
FATHER				
SISTER(S)				
BROTHER(S)				
CHILDREN				