ALLERGY CLINIC

Name: _____

DOB: _____ **MRN:** _____

DATE: _____

Are you currently experiencing any of the following symptoms?

CONSTITUTIONAL

YES	NO	
☐	☐	Appetite changes (Increased/Decreased)
☐	☐	Chills
☐	☐	Fatigue (feeling run down)
☐	☐	Fever
☐	☐	Malaise (feeling of uneasiness)
☐	☐	Weight changes – Indicate (gain / loss)

HEAD/EARS/EYES/NOSE/THROAT

YES	NO	
☐	☐	Headache
☐	☐	Blurry Vision
☐	☐	Burning sensation of eyes
☐	☐	Visual changes (double vision / lights bother eyes)
☐	☐	Eye drainage (clear or discolored)
☐	☐	Dry eyes
☐	☐	Eye redness
☐	☐	Itchy eyes
☐	☐	Facial pain
☐	☐	Ear drainage
☐	☐	Fullness in ears
☐	☐	Ear pain
☐	☐	Dizziness
☐	☐	Disturbance in sense of smell
☐	☐	Nose bleeds
☐	☐	Nasal congestion
☐	☐	Recurrent sinusitis
☐	☐	Sneezing
☐	☐	Hoarseness of voice
☐	☐	Drainage in back of throat from nose
☐	☐	Sore throat
☐	☐	Snoring

LUNGS

YES	NO	
☐	☐	Cough (DRY or PRODUCTIVE) If productive, what color _____
☐	☐	Recurrent bronchitis or pneumonia
☐	☐	Chest pain (pain with deep breath)
☐	☐	Shortness of breath / difficulty breathing
☐	☐	Wheezing

HEART/VASCULAR

YES	NO	
☐	☐	Chest pain (cardiac)
☐	☐	Heart murmur
☐	☐	Swelling in legs
☐	☐	Abnormal heartbeat / palpitations
☐	☐	Passing out

STOMACH/COLON

YES	NO	
☐	☐	Pain in abdomen (belly)
☐	☐	Constipation
☐	☐	Diarrhea
☐	☐	Heartburn
☐	☐	Nausea
☐	☐	Vomiting

GENITAL/URINARY

YES	NO	
☐	☐	Painful urination
☐	☐	Frequent urination
☐	☐	Blood in urine

ENDOCRINE

YES	NO	
☐	☐	Cold intolerance
☐	☐	Decreased activity
☐	☐	Heat intolerance
☐	☐	Increased thirst (unexplained)
☐	☐	Increased hunger (unexplained)

MENTAL HEALTH

(Have you been diagnosed or treated for …)

YES	NO	
☐	☐	Anxiety
☐	☐	Depression
☐	☐	Difficulty sleeping

NEUROLOGIC

YES	NO	
☐	☐	Light headedness
☐	☐	Passing out

SKIN

YES	NO	
☐	☐	Contact dermatitis
☐	☐	Itchy skin
☐	☐	Rash
☐	☐	Skin lesions

MUSCULOSKELETAL

YES	NO	
☐	☐	Bone/joint symptoms
☐	☐	Generalized body aches
☐	☐	Muscle weakness

BLOOD/BLEEDING PROBLEMS

YES	NO	
☐	☐	Difficulty controlling bleeding
☐	☐	Easy bruising
☐	☐	Lymph node enlargement

IMMUNE SYSTEM

(Are you being treated for or have you been diagnosed with ...)

YES	NO	
☐	☐	Hay fever (seasonal allergies)
☐	☐	Hives
☐	☐	Animals at work / work If yes, what kind _____
☐	☐	Asthma
☐	☐	Bee sting allergies

TRIGGERS

(Do any of the following aggravate allergy or breathing symptoms?)

YES	NO	
☐	☐	Change of seasons
☐	☐	Mold
☐	☐	Pet dander (type of pet _____)
☐	☐	Dust
☐	☐	Weather
☐	☐	Pollution / odor contaminants
☐	☐	Smoke (i.e. fire burning or bbq)
☐	☐	Exercise
☐	☐	Something you touch/come in contact with (List _____)
☐	☐	Latex or rubber

ALLERGIES

YES	NO	
☐	☐	Environmental
☐	☐	Foods
☐	☐	Medication (List _____)

Temp _____ BP _____ Pulse _____ Resp Rate _____ Pulse Ox _____