**FERRELL-DUNCAN CLINIC -- ALLERGY/IMMUNOLOGY**

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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

First Middle Last

Age: \_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Weight: \_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Were you referred by a physician/health care provider? □ Yes □ No

If Yes, please provide us with the name, address, and phone number of the physician referring you:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Would you like us to send a letter to your primary care provider regarding your visit with us? □ Yes □ No

If Yes, please provide us with the name, address, and phone number of your primary care provider:

□ Same as referring provider

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If there are other providers whom you wish to receive copies of our evaluation, please list the names, addresses, and phone numbers here:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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The following new patient questionnaire is detailed. Please take the time to fill it out before your visit to help you recall important features of your condition and help our doctors diagnose and treat you. Thank you!

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Allergy Physician/NP Signature Date

**Current Medications:**

|  |  |  |  |
| --- | --- | --- | --- |
| Medication name | Dose | Frequency | Last taken when? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
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**Previous Allergy/Asthma Medications You Have Taken:**

|  |  |  |
| --- | --- | --- |
| Medication name | Did it help? | Last taken when? |
|  | □ No □ Yes |  |
|  | □ No □ Yes |  |
|  | □ No □ Yes |  |
|  | □ No □ Yes |  |

**Medication/Food/Other Allergies:**

Have you ever had an adverse/allergic reaction to a medication, food, chemical, or other product? □ No □ Yes

If yes, please describe to what drug(s)/food(s)/other product(s), approximate year of the reaction, and type of reaction.

|  |  |  |
| --- | --- | --- |
| Medication/food/product name | Year | Type of reaction |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Past Medical History:**

Major Diagnoses/Illnesses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Surgical History: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Immunizations: Year of last Tetanus shot: \_\_\_\_\_\_\_\_ Year of last seasonal flu shot: \_\_\_\_\_\_\_\_

Year of last pneumonia shot: \_\_\_\_\_\_\_\_\_

Up to date on childhood immunizations: □ Yes □ No

Describe any reactions to immunizations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

**General:** □ Chills □ Malaise (general feeling of illness)

□ Decreased appetite □ Sweating

□ Fatigue □ Weight gain

□ Fever □ Weight loss

**Eye:** □ Blurred vision □ Photophobia (light sensitivity)

□ Double vision □ Redness

□ Drainage □ Tearing/watering

□ Itching □ Vision loss

□ Pain □ Visual changes

**ENT:** □ Decreased hearing □ Loss of smell □ Swollen glands

□ Dental pain □ Nasal congestion □ Tinnitus (ringing in the ears)

□ Ear drainage □ Postnasal drip

□ Ear pain □ Rhinorrhea (runny nose)

□ Frequent nosebleeds □ Sinus pressure

□ Hoarseness □ Sore throat

**Cardiovascular:** □ Chest pain □ Fainting

□ Shortness of breath with exertion □ Palpitations (heart racing/skipping beats)

□ Edema (leg swelling)

**Respiratory:** □ Cough □ Snoring

□ Shortness of breath at rest □ Wheezing

**GI:** □ Constipation □ Diarrhea □ Nausea

□ Heartburn □ Vomiting

**GU:** □ Blood in the urine □ Painful urination □ Incontinence

□ Frequent urination □ Night time urination

**MS:** □ Joint pain □ Muscle pain □ Muscle weakness

□ Joint swelling

**Skin:** □ Pruritis (itching) □ Rash

**Neuro:** □ Memory problems □ Seizures □ Vertigo (dizziness)

**Psych:** □ Anxious mood □ Depressed mood □ Poor attention span

**Endocrine:** □ Change in hair texture □ Temperature intolerance

**Heme/Lymph:** □ Abnormal bruising

**Allergy/Imm:** □ Frequent infections □ Hives □ Seasonal allergies

**FAMILY HISTORY**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  | Mother | Father | Sister | Brother | Maternal  Grand  Mother | Maternal  Grand  Father | Paternal  Grand  Mother | Paternal  Grand  Father | Other Family  Member  (list relationship) |
| Angioedema (lip swelling) | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Asthma | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Autoimmune disease | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Cancer | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Cystic Fibrosis | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Diabetes | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Eczema | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Emphysema | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Food allergies | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Heart disease | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Hives | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Seasonal allergies | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |
| Thyroid disease | □ | □ | □ | □ | □ | □ | □ | □ | \_\_\_\_\_\_\_\_\_\_\_ |

**SOCIAL HISTORY**

**Tobacco Use:** □ Current smoker – every day **Type:** **Tobacco Use Per Day:**

□ Current smoker – some days □ Chewing tobacco □ < 1/4 pack per day

□ Former smoker □ Cigarettes □ < 1/2 pack per day

□ Quit less than 30 days ago □ Cigars □ 1/2 pack per day

□ Quit more than 30 days ago □ Pipe □ 1 pack per day

□ Never smoked □ E-cigs □ 1 1/2 packs per day

□ 2 packs per day

Number of years used: \_\_\_\_\_\_ □ 3 packs per day

□ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there smokers in the patient’s home? □ Yes □ No

**Alcohol**: □ None □ Past □ Current (indicate frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Substance Use:** □ None □ Past □ Current (indicate type & frequency): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home:**  Marital Status: □ Single □ Married □ Widowed □ Divorced □ Separated

Lives with: □ Alone □ Children □ Father □ Mother

□ Siblings □ Significant Other □ Spouse □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment/School:**  □ Full time □ Part time □ Student □ Retired □ Unemployed

□ Disability □ Homemaker □ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergens:** Days of work/school missed yearly on average due to respiratory symptoms: \_\_\_\_\_\_\_\_\_\_

**Air Conditioning:** **Air Filter:** **Basement:**

□ Central □ Disposable □ Damp

□ Makes symptoms better □ Electronic □ Dry

□ Window unit □ Electronstatic □ Dehumidifier in use

□ None □ HEPA filter □ Finished

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Musty

□ N/A (crawlspace)

□ N/A (slab home)

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bedding:** **Bedroom Curtains:** **Bedroom Flooring:**

□ Washed in cold water □ Blinds □ Area rug

□ Washed in hot water □ Cloth curtains □ Carpet

□ Washed monthly □ Shadees □ Hardwood

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Linoleum

□ Tile

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Bedroom Location:** □ Above ground □ In basement □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Cat:** **Dog:** **Home Heat Source:**

□ Indoor □ Indoor □ Electric

□ Outdoor □ Outdoor □ Natural gas

□ At daycare □ At daycare □ Propane

□ None □ None □ Wood

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Type:** **Housedust Precautions: Humidifier:**

□ Apartment □ Implemented □ Attached to furnace

□ City/suburban □ Partially implemented □Free standing

□ House □ Not implemented □ None

□ Townhouse

□ Rural/farm

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Main Flooring:** **Mattress:** **Other Pets:**

□ Area rug □ Dust proof/allergy cover □ Birds

□ Carpet □ New □ Guinea pigs/hamsters

□ Hardwood □ Old □ Horses

□ Linoleum □ Standard □ Rabbits

□ Tile □ Waterbed □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ □ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Pillow:** **Wood Stove Exposure:** **Daycare:**

□ Dust proof/allergy cover □ Yes □ Yes

□ Feather □ No □ No

□ New

□ Old

□ Synthetic

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGY/IMMUNOLOGY HISTORY**

Please describe in your own words the primary medical problem and duration of symptoms that brought you to our office:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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When did your symptoms start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mark the symptomatic months: □ Jan □ Feb □ Mar □ Apr □ May □ June □ Jul □ Aug □ Sep □ Oct □ Nov □ Dec

□ Spring □ Summer □ Fall □ Winter □ All year round

**Triggers:**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Eye/nasal symptoms worsened by: | | | | | | |
| □ smoke | □ aerosols | □ dust | □ perfumes | □ basements | □ cats | □ dogs |
| □ cold air | □ wind | □ beer/wine | □ temp changes | □ humidity | □ rain | □ season changes |
| □ heartburn | | □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | |
| Lung symptoms worsened by: | | | | | | |
| □ smoke | □ aerosols | □ dust | □ perfumes | □ basements | □ cats | □ dogs |
| □ cold air | □ wind | □ beer/wine | □ temp changes | □ humidity | □ rain | □ season changes |
| □ activity | □ resp infection | □ laughing | □ heartburn | □ aspirin products | | |
| □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |
| Skin symptoms worsened by: | | | | | | |
| □ heat | □ exercise | □ sunlight | □ cold | □ vibration | □ water | □ vibration |
| □ rubbing | □ scratching | □ wool | □ cut grass | □ leaves | □ plants | □ poison ivy/oak |
| □ soaps | □ cosmetics | □ menstrual cycle | □ foods: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |
| □ other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | | | | |

**Skin history:** (hives, rash, swelling, angioedema: skip if no skin problems):

Skin problems: □ eczema □ rash □ hives □ swelling □ itching □ dry skin

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Features: | Date of onset: \_\_\_\_\_\_\_\_\_\_\_\_\_ | | Worse in: | □ AM | □ PM | □ after meals | □ all day |  |
|  | Affected areas: | □ hands | □ arms | □ feet | □ legs | □ stomach | □ back | □ head/face |
|  | Appearance: | □ red | □ flat | □ raised | □blistery | □ leaves marks/bruises | | |
|  |  | □ moves around | | □ stays in one spot | | how long does it last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | |

Current Skin: soap: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ shampoo: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ conditioner: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Products detergent: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ fabric softener: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

toothpaste: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ cosmetics: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

perfumes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ any scent changes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Stings: reactions to: □ bees reaction type: □ large local reactions

□ wasps □ hives □ wheezing

□ hornets □ throat swelling □ nausea/diarrhea

□ fire ants □ unconsciousness

□ mosquitoes □ required emergency treatment

□ chiggers age at time of first reaction: \_\_\_\_\_\_\_\_

Tick bites/exposure: □ No □ Yes When did last bite occur? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Anaphylaxis:**

Other history of anaphylaxis? □ No □ Yes Age at time of reaction: \_\_\_\_\_ Trigger if known: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_