



2315 W. 57th Street • Sioux Falls, SD 57108
(605) 275-1228 • 888-336-3503
Fax (605) 275-2056

NAME: _____

DATE: _____ PT ID#: _____

HOME #: _____ WORK #: _____

CELL #: _____

AGE: _____ AGE AT WHICH SYMPTOMS BEGAN: _____

SYMPTOMS: *(Indicate from the list below)*

- | | | | | |
|-------------------------------------|---|--|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Nasal congestion | <input type="checkbox"/> Red/watery eyes | <input type="checkbox"/> Headaches/migraines | <input type="checkbox"/> Nausea |
| <input type="checkbox"/> Colds | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Itchy mouth | <input type="checkbox"/> Fever | <input type="checkbox"/> Indigestion |
| <input type="checkbox"/> Sneezing | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Runny nose | <input type="checkbox"/> Scratchy throat | <input type="checkbox"/> Ears popping | <input type="checkbox"/> Rashes/hives | <input type="checkbox"/> Abdominal pain/gas |

List your top three symptoms starting with the most bothersome.

1. _____ 2. _____ 3. _____

FREQUENCY/TIME OF SYMPTOMS: *(Check corresponding boxes below)*

_____ Sporadic (at various times of year but with no pattern)

_____ Persistent (throughout the year)

_____ Seasonal (indicate the prominent months below)

- | | | | | | |
|-------------------------------|------------------------------|--------------------------------|--------------------------------|------------------------------|-------------------------------|
| <input type="checkbox"/> Jan | <input type="checkbox"/> Feb | <input type="checkbox"/> March | <input type="checkbox"/> April | <input type="checkbox"/> May | <input type="checkbox"/> June |
| <input type="checkbox"/> July | <input type="checkbox"/> Aug | <input type="checkbox"/> Sept | <input type="checkbox"/> Oct | <input type="checkbox"/> Nov | <input type="checkbox"/> Dec |

SURROUNDINGS: *(Indicate where/when symptoms occur)*

- | | | | | |
|---|---|-------------------------------------|--|--|
| <input type="checkbox"/> After mowing | <input type="checkbox"/> By burning leaves | <input type="checkbox"/> At school | <input type="checkbox"/> Animals | <input type="checkbox"/> Change of seasons |
| <input type="checkbox"/> In damp areas | <input type="checkbox"/> Near farms | <input type="checkbox"/> At work | <input type="checkbox"/> Spring | |
| <input type="checkbox"/> While driving | <input type="checkbox"/> Sitting on furniture | <input type="checkbox"/> In bedroom | <input type="checkbox"/> Fall | |
| <input type="checkbox"/> Out walking | <input type="checkbox"/> Reading a book | <input type="checkbox"/> In kitchen | <input type="checkbox"/> Hot weather | |
| <input type="checkbox"/> While exercising | <input type="checkbox"/> In basement | <input type="checkbox"/> In attic | <input type="checkbox"/> Weather changes | |

ARE YOU FREQUENTLY EXPOSED TO:

- | | |
|---|--|
| <input type="checkbox"/> Indoor pets | <input type="checkbox"/> Books/papers |
| <input type="checkbox"/> Plants/flowers | <input type="checkbox"/> Stuffed furniture |
| <input type="checkbox"/> Basements | <input type="checkbox"/> Chemicals |
| <input type="checkbox"/> Attics | <input type="checkbox"/> Farms/Crop fields |
| <input type="checkbox"/> Dust | |

Do you smoke? Yes No

Are you around 2nd hand smoke? Yes No

Do you drink alcohol? Yes No

If Yes, number of drinks per week? _____

LIST TYPE OF:

Home _____ (single family, apt/condo, mobile home)

Heating system _____ (central, gas, electric, etc)

Floor coverings _____ (carpet, wood, linoleum, etc.)

Pillows _____ (foam, feather, cotton)

Mattress _____ (cotton, feather, foam rubber, waterbed)

PETS: *(Indicate animals you are frequently exposed to)*

- | | | | |
|------------------------------|---------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Dog | <input type="checkbox"/> Rabbit | <input type="checkbox"/> Bird | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cat | <input type="checkbox"/> Horse | <input type="checkbox"/> Hamster | |

PREVIOUS ALLERGY TESTING:

Have you ever been tested for allergies? Yes No

If Yes:

When: _____

Where: _____

Method: Skin Test
 Blood Test

FAMILY HISTORY: *(Indicate members of your family who have been tested for allergies and are positive)*

Mother Sister Grandmother
 Father Brother Grandfather

MEDICAL HISTORY: *(Check if you now have or have ever been diagnosed with)*

<input type="checkbox"/> Diabetes	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Bronchitis
<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Thyroid problems
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Asthma	<input type="checkbox"/> Severe allergic reaction
<input type="checkbox"/> Stroke	<input type="checkbox"/> Depression	<input type="checkbox"/> Psychiatric disorders
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Cancer	<input type="checkbox"/> Sleeping disorders
<input type="checkbox"/> Kidney or Liver problems	<input type="checkbox"/> Seizure disorder	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Migraines	_____

***Women:** Are you pregnant now or think you may be? Yes No

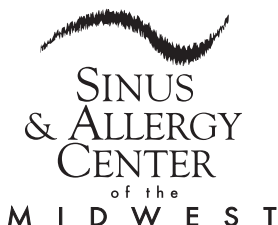
LIST ALL MEDICATIONS THAT YOU CURRENTLY TAKE:

(Including over-the-counter and herbal supplements)

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Signature: _____
(Patient or Guardian)

Date: _____



2315 W. 57th Street • Sioux Falls, SD 57108
(605) 275-1228 • 888-336-3503
Fax (605) 275-2056