Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_­­­­\_\_\_\_\_\_ Birthdate \_\_\_\_\_\_\_\_\_\_\_ Visit date \_\_\_\_\_\_\_\_\_\_\_

|  |
| --- |
| Please describe the problem that brings you to us: |
|  |
|  |
| When did it start? |
| What makes it better? |
| What makes it worse? |
| What treatments have not worked? |

Please indicate the months symptoms are worse [if applicable]:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

NONE [same regardless of season]

|  |  |  |  |
| --- | --- | --- | --- |
| Other exposures that make symptoms worse (please check all that apply): | | | |
| ☐ Outdoors  ☐ Dry windy days  ☐ Mowing grass | ☐ Indoors  ☐ House dust  ☐ Moldy areas | | ☐ Around cats  ☐ Around dogs  ☐ Other: |
| Have you had allergy testing before? Yes ☐ No ☐  If yes, what were the results? | | | |
| Have you had allergy shots before? Yes ☐ No ☐  If yes, what were the results? | | | |
| How long have you lived in Colorado?  Areas or climates where you have lived previously? | | | |
| Do you have pets?  ☐ No  ☐ Yes: Dog Cat Bird Other: | | Previous water damage or areas of visible mold growth? ☐ No  ☐ Yes | |
| Your occupation: | | | |
| Does contact with metal, soap, lotion, perfume, etc. cause a rash? Yes ☐ No ☐ | | | |
| Do you react to any certain foods? Yes ☐ No ☐  If yes, please describe: | | | |
| Do Insect stings cause difficulty breathing, throat swelling, loss of consciousness? Yes ☐ No ☐ | | | |
| Are you allergic to latex? Yes ☐ No ☐  If yes, please describe your reaction: | | | |
| Do you have atopic dermatitis [‘eczema’]? Yes ☐ No ☐  If yes, current treatment | | | |
| Medications: severe or unusual reactions? Yes ☐ No ☐  If yes, please describe: | | | |
| Immunizations: severe or unusual reactions? Yes ☐ No ☐  If yes, please describe: | | | |

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Eye Symptoms | Itching |  | Burning |  | Excessive Tearing |  | Glaucoma |  |
| None ☐ | Dark Circles |  | Dryness |  | Wear Contact Lenses |  | Cataracts |  |
|  |  | | | | | | | |
| Ear Symptoms: | Itching |  | Popping |  | Hearing Loss |  | Earache |  |
| None ☐ | Pe Tubes |  | Congested |  | Frequent Infections |  | Other: |  |
|  |  | | | | | | | |
| Nasal Symptoms | Sneezing |  | Runny Nose |  | Loss Of Sense Of Smell |  | Broken Nose |  |
| None ☐ | Itching |  | Congestion |  | Green/Yellow Mucous |  | Other: |  |
|  |  | | | | | | | |
| Oral Symptoms: | Hoarseness |  | Snoring |  | Difficulty Swallowing |  | Other: | |
| None ☐ | Throat Clearing |  | Tooth Pain |  | Postnasal Drip |  |
|  |  | | | | | | | |
| Headache | Under Eyes |  | Behind Eyes |  | Temples |  | Forehead |  |
| None ☐ | Migraine |  | Other: | | | | | |
|  |  | | | | | | | |
| Chest Symptoms: | Cough |  | Tightness |  | Shortness Of Breath |  | Wheezing |  |
| None ☐ | Pain |  | Mucous |  | Other: | | | |
|  |  |  |  |  |  |  |  |  |
| GI Symptoms: | Heartburn |  | Diarrhea |  | Frequent Constipation |  | Ulcers |  |
| None ☐ | Pain |  | Nausea |  | Other: | | | |
|  |  | | | | | | | |
| Skin Symptoms: | Hives |  | Itchy Skin |  | Psoriasis |  | Eczema |  |
| None ☐ | Swelling |  | Other: | | | | | |
|  |
| Cardiovascular | Heart Problems |  | Palpitations |  | Chest Pain Or Pressure With Exertion | | |  |
| None ☐ | Hypertension |  | Other: | | | | | |
|  |  | | | | | | | |
| Constitutional: None ☐ | Fever |  | Chills |  | Unexplained Weight Loss | | |  |
|  |  | | | | | | | |
| Musculoskeletal: None ☐ | Arthritis |  | Autoimmune |  | Artificial Joint |  | Other: |  |
|  |  | | | | | | | |
| Neurologic:  None ☐ | Previous Stroke |  | Other Neurologic Problems: | | | | | |
|  |  | | | | | | | |
| Psychiatric:  None ☐ | Anxiety |  | Depression |  | Other: | | | |

|  |  |  |
| --- | --- | --- |
| Medications -- please list all: | |  |
| Other medical problems: |
|  | | | |

Previous surgeries: None ☐

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Tonsillectomy |  | Tubes In Ears | Other: |  |
|  | Sinus Surgery |  | Chest Surgery |  |

Family: Do Any Immediate\* Family Members Have :

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
|  | Allergies [‘Hayfever’] |  | Eczema |  | Cystic Fibrosis |
|  | Asthma |  | Celiac Disease |  | Serious Infections |
|  | Swelling Episodes |  | Emphysema |  | Death In Infancy |

|  |
| --- |
| Do you smoke tobacco? Yes ☐ No ☐ If yes, how many years? How many packs per day? |
| For women : Are you pregnant, trying to conceive, or nursing a baby? Yes ☐ No ☐ |

**NASAL SYMPTOMS:**

During the past WEEK, how often did you have a ‘stuffy nose’?

(5) Never ☐

(4) Rarely (Once or Twice) ☐

(3) Sometimes (Less Than Half the Time) ☐

(2) Often (Just About Everyday) ☐

(1) Very Often/Constantly ☐

During the past WEEK, how often did you sneeze?

(5) Never ☐

(4) Rarely (Once or Twice) ☐

(3) Sometimes (Less Than Half the Time) ☐

(2) Often (Just About Everyday) ☐

(1) Very Often/Constantly ☐

During the past WEEK, how often did you have excessively watery eyes?

(5) Never ☐

(4) Rarely (Once or Twice) ☐

(3) Sometimes (Less Than Half the Time) ☐

(2) Often (Just About Everyday) ☐

(1) Very Often/Constantly ☐

During the past WEEK, to what extent did your allergy symptoms interfere with your sleep?

(5) Never ☐

(4) Rarely (Once or Twice) ☐

(3) Sometimes (Less Than Half the Time) ☐

(2) Often (Just About Everyday) ☐

(1) Very Often/Constantly ☐

During the past WEEK, how often did you avoid any activity (for ex, gardening, exercise, visiting a house with a cat or dog) because of your nasal or other allergy symptoms?

(5) Never ☐

(4) Rarely (Once or Twice) ☐

(3) Sometimes (Less Than Half the Time) ☐

(2) Often (Just About Everyday) ☐

(1) Very Often/Constantly ☐

SCORE: \_\_\_\_\_

Do you have a recurring cough, shortness of breath, wheezing, episodes of ‘bronchitis’?

Yes ☐…..please answer remaining questions on the last page

No ☐…...questionnaire complete.

Please fax, email or bring this questionnaire to your appointment.

Thank you!

Fax (844) 269-5420

Email [no-reply@alligatorallergy.com](mailto:no-reply@alligatorallergy.com)

**LUNG SYMPTOMS**

In the past 4 weeks, how much of the time did your asthma keep you from getting as much done at work, school, or home?

(5) None of the time ☐

(4)A little of the time ☐

(3) Some of the time ☐

(2) Most of the time ☐

(1) All of the time ☐

During the past 4 weeks, how often have you had shortness of breath?

(5) Not at all ☐

(4) Once or twice a week ☐

(3) Three to six times a week ☐

(2) Once a day ☐

(1) More than once a day ☐

During the past 4 weeks, how often did your asthma symptoms (wheezing, coughing, shortness of breath, chest tightness, or pain) wake you up at night or earlier than usual in the morning?

(5) Not at all ☐

(4) Once or twice ☐

(3) Once a week ☐

(2) Two or three nights a week ☐

(1) Four or more nights a week ☐

During the past 4 weeks, how often have you used your rescue inhaler or nebulizer medication (such as albuterol, Ventolin, Proventil, or Maxair)?

(5) Not at all ☐

(4) Once a week or less ☐

(3) Two or three times a week ☐

(2) One to two times a day ☐

(1) Three or more times a day ☐

How would you rate your asthma control during the past 4 weeks?

(5) Completely controlled ☐

(4) Well controlled ☐

(3) Somewhat controlled ☐

(2) Poorly controlled ☐

(1) Not controlled at all ☐

SCORE \_\_\_\_\_\_

Any asthma ‘attacks,’ urgent or emergency room visits for asthma? Yes ☐ No ☐ If yes,when?

Have you ever been hospitalized for asthma? Yes ☐ No ☐ If yes, when?

----------------------------------------------------QUESTIONNAIRE COMPLETE----------------------------------------------

Please fax, email or bring to your appointment. Thank you!

Fax (844) 269-5420 Email [no-reply@alligatorallergy.com](mailto:no-reply@alligatorallergy.com)