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ALLIGATOR ALLERGY & ASTHMA

Name _____ Birthdate _____ Date today _____

When did your rash begin?

Does it occur consistently after any particular food or activity?

_____

_____

Please list all medications and supplements that you take regularly **and when you started taking them.** Please continue on back if needed.

Date begun: Medication or supplement:

_____ _____

_____ _____

_____ _____

_____ _____

Please list ALL other medications or supplements that you take on occasion: [for example, aspirin, ibuprofen, etc], and if you have noted that the rash occurs or worsens afterward. Please continue on back if needed.

Medication / supplement: Notations:

_____ _____

_____ _____

_____ _____

Does the rash itch? YES NO

Are there blisters? YES NO

Are there pustules ['white-heads']? YES NO

Where on the body does the rash begin? _____

Do the individual 'spots' of the rash last longer than 24 hours? YES NO

Do the individual 'spots' leave a bruise? YES NO

Had you had an illness in the few weeks prior to the start of the rash? [flu, cold, diarrhea, or other possible infection]? YES NO

Have you had new joint aches associated with the rash? YES NO

Any unexplained weight change in the past few months? YES NO

Do you have any bone pain? YES NO

Have you noticed any swollen lymph nodes? YES NO

Do you have latex reactions [e.g., to blowing up latex balloons or with use of latex gloves]? YES NO

With the rash do you have wheezing? Difficulty breathing? Throat swelling? Nausea, vomiting? Abdominal pain? Lightheadedness? 'Racing' heart? 'Passing out'? [please circle all that apply]

Have you had this rash in the past? YES NO

In the 4 hours before the rash appeared had you ingested any new foods, beverages, candy, etc? YES NO

If yes, what?

_____

Does the rash start consistently during or just after exercise? YES NO

Are you always hot or cold when others are comfortable? YES NO

Did you travel abroad in the few months before the rash started? YES NO

If so, where? _____

Do you eat raw fish; e.g., sashimi, sushi, etc? YES NO

Do you have severe itching in the area of the rectum? YES NO

Does the rash occur consistently… [please circle all that apply]

With exposure to cold temperature?
With exposure to hot temperature?
When sweating?
In areas of pressure [such as shoulder straps, belts, etc]?
In areas exposed to the sun?
In areas exposed to water?

Does contact with any type of metal or jewelry cause a rash or excessive irritation of your skin? YES NO

Do your parents, grandparents, or siblings have 'hives?' YES NO
Episodes of swelling [e.g., swelling of the lips, tongue, hands]? YES NO
Deafness from birth? YES NO

Does your rash occur in certain seasons of the year [e.g., spring, summer, fall, winter]? YES NO
If so, circle months: JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

What medications work for your symptoms?

What medications have not worked?

Environment:

How long have you lived in the Colorado / Rocky Mountain area?

Areas or climates where you have lived previously?

Does your home have. . .

central air conditioning? yes ☐ no ☐
central heat? yes ☐ no ☐
Pets? yes ☐ no ☐
If yes, type? dog cat bird other:

wall to wall carpeting? yes ☐ no ☐
previous uncorrected water damage? yes ☐ no ☐
areas of visible mold growth? yes ☐ no ☐
indoor hot tub / area of high humidity? yes ☐ no ☐

Occupation / hobby exposures:

Other allergies:

Do you have asthma? yes ☐ no ☐

Do you have allergies affecting the nose, sinuses, eyes? yes ☐ no ☐

Exposures that make your symptoms worse (please indicate all that apply):

outdoors		indoors	at work	around cats
dry windy days		at home	moldy areas	around dogs
mowing grass		house dust	chemicals	other [please describe]:

Do you avoid certain foods due to adverse reactions? yes ☐ no ☐
If yes, please describe:

Insect sting reactions? yes ☐ no ☐
If yes, please describe: hives, difficulty breathing, throat swelling other:

Insect: bee, wasp, yellow jacket, hornet, fire ant, other:

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:

Review of Systems								
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:			
Abdominal symptoms:	heartburn		diarrhea		frequent constipation		ulcers	
none ☐	pain		nausea		other:			
Skin symptoms:	hives		itchy skin		sensitivity to metals		eczema	
none ☐	swelling		other:					
Cardiovascular	heart problems		palpitations		Chest pain or pressure with exertion			
none ☐	hypertension		other:					
Constitutional:	fever		chills		unexplained weight loss			
none ☐								
Musculoskeletal:	joint swelling		stiffness		pain			
none ☐								
Neurological:	previous stroke		other neurologic problems:					
none ☐								
Psychiatric:	emotional problems		depression		other:			
none ☐								

Other medical problems / diagnoses [please list all]:

Have you used tobacco? Yes ☐ No ☐ If yes, how much and how long?

Surgery that you have had:
none ☐

tonsillectomy		nasal septum repair		tubes in ears		sinus surgery	
nasal polyp removal		Chest surgery		Other [please list all]:			

Family history: please indicate which immediate family members [e.g., biologic mother, father, sisters or brother] have:

allergies ['hayfever']		eczema		cystic fibrosis	
asthma		celiac disease		serious infections	
swelling episodes		emphysema		death in infancy	

For women : Are you pregnant, trying to conceive, or nursing a baby? yes ☐ no ☐

For children < 12 years old, please indicate all that apply:

food allergy		frequent bronchitis		eczema		
colic		bronchiolitis		frequent skin rashes		
problems with formula		asthma		Other:		
growth problems		developmental delay				