

Name _____ Birthdate _____ Visit Date _____

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:

| | |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Please circle the answer that best applies to you:

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 any of the following symptoms?
[please circle all that apply]

| | | | |
|------------------|----------------------|-----------------|----------------|
| Wheezing | Difficulty breathing | Throat swelling | 'Racing' heart |
| Nausea, vomiting | Abdominal pain | Lightheadedness | 'Passing out' |

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 <input type="checkbox"/> No <input type="checkbox"/> | Wall To Wall Carpeting? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Central Heat? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Previous Uncorrected Water Damage? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| Pets? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Areas Of Visible Mold Growth? | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If Yes, Type? Dog Cat Bird | Other: | Indoor hot tub / area of high humidity? | Yes <input type="checkbox"/> No <input type="checkbox"/> |

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 none <input type="checkbox"/> | Itching | | Burning | | Excessive Tearing | | Glaucoma |
| | Dark Circles | | Dryness | | Wear Contact Lenses | | Cataracts |
| Ear Symptoms: none <input type="checkbox"/> | Itching | | Popping | | Hearing Loss | | Earache |
| | Pe Tubes | | Congested | | Frequent Infections | | Other: |
| Nasal Symptoms none <input type="checkbox"/> | Sneezing | | Runny Nose | | Loss Of Sense Of Smell | | Broken Nose |
| | Itching | | Congestion | | Green/Yellow Mucous | | Other: |
| Oral symptoms: none <input type="checkbox"/> | Hoarseness | | Snoring | | Difficulty Swallowing | | Other: |
| | Throat Clearing | | Tooth Pain | | Postnasal Drip | | |
| Headache none <input type="checkbox"/> | Under Eyes | | Behind Eyes | | Temples | | Forehead |
| | Migraine | | Other: | | | | |
| Chest symptoms: none <input type="checkbox"/> | Cough | | Tightness | | Shortness Of Breath | | Wheezing |
| | Pain | | Mucous | | Other: | | |
| Abdominal symptoms: none <input type="checkbox"/> | Heartburn | | Diarrhea | | Frequent Constipation | | Ulcers |
| | Pain | | Nausea | | Other: | | |
| Skin symptoms: none <input type="checkbox"/> | Hives | | Itchy Skin | | Sensitivity To Metals | | Eczema |
| | Swelling | | Other: | | | | |
| Cardiovascular none <input type="checkbox"/> | Heart Problems | | Palpitations | | Chest Pain Or Pressure With Exertion | | |
| | Hypertension | | Other: | | | | |
| Constitutional: none <input type="checkbox"/> | Fever | | Chills | | Unexplained Weight Loss | | |
| Musculoskeletal: none <input type="checkbox"/> | Joint Swelling | | Stiffness | | Pain | | |
| Neurological: none <input type="checkbox"/> | Previous Stroke | | Other Neurologic Problems: | | | | |
| Psychiatric: none <input type="checkbox"/> | Emotional Problems | | Depression | | Other: | | |

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 | | | | |

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

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

Thank you!

Fax (844) 269-5420

Email no-reply@alligatorallergy.com