

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):

- | | | |
|---|--------------------------------------|--------------------------------------|
| <input type="checkbox"/> Outdoors | <input type="checkbox"/> Indoors | <input type="checkbox"/> Around cats |
| <input type="checkbox"/> Dry windy days | <input type="checkbox"/> House dust | <input type="checkbox"/> Around dogs |
| <input type="checkbox"/> Mowing grass | <input type="checkbox"/> Moldy areas | <input type="checkbox"/> 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? | Previous water damage or areas of visible mold growth? |
| <input type="checkbox"/> No | <input type="checkbox"/> No |
| <input type="checkbox"/> Yes: Dog Cat Bird Other: | <input type="checkbox"/> 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 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:	

GI Symptoms: None <input type="checkbox"/>	Heartburn	Diarrhea	Frequent Constipation	Ulcers
	Pain	Nausea	Other:	

Skin Symptoms:	Hives	Itchy Skin	Psoriasis	Eczema
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None <input type="checkbox"/>	Swelling	Other:		
Cardiovascular	Heart Problems	Palpitations	Chest Pain Or Pressure With Exertion	
None <input type="checkbox"/>	Hypertension	Other:		
Constitutional:	Fever	Chills	Unexplained Weight Loss	
None <input type="checkbox"/>				
Musculoskeletal:	Arthritis	Autoimmune	Artificial Joint	Other:
None <input type="checkbox"/>				
Neurologic:	Previous Stroke	Other Neurologic Problems:		
None <input type="checkbox"/>				
Psychiatric:	Anxiety	Depression	Other:	
None <input type="checkbox"/>				

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'?

Yesplease answer remaining questions on the last page

Noquestionnaire complete.

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

Thank you!

Fax (844) 269-5420

Email 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!

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