ALLIGATOR
ALLERGY & ASTHMA

4194 Royal Pine Drive, Colorado Springs, CO 80920
Phone: (719) 344-5355 Fax: [844] 269-5420

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 conscousness? 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 enses		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 none ☐	heart problems		palpitations		chest pain or pressure with exertion			
	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'?

No ☐…...questionnaire complete. Please fax, email or bring this questionnaire to your appointment.

Thank you!
Fax (844) 269-5420
Email suppport@alligatorallergy.com.

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

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 suppport@alligatorallergy.com.