

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 | 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’?

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

Thank you!

Fax (844) 269-5420

Email suppport[@alligatorallergy](mailto:NO-REPLY@alligatorallergy.com).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](mailto:NO-REPLY@alligatorallergy.com).com.