ALLIGATOR
ALLERGY & ASTHMA

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RETURNING PATIENTS - OFFICE VISIT

Name _____ **Date of birth** _____ **Date** _____

What is your chief concern regarding your allergies today?

_____

_____

If you are still having allergy symptoms, which months are worse? [circle] SAME ALL YEAR

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC

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

	outdoors		indoors		at work		around cats
	dry windy days		at home		moldy areas		around dogs
	mowing grass		house dust		chemicals		exertion

other [please describe]:

Medications Please list all medications you take daily:

_____

_____

Any new medical problems or surgeries?

_____

Updates on your environment:
Does your home have.....

Pets? yes ☐ no ☐ If yes, what kind?
central air conditioning? yes ☐ no ☐
central heat? yes ☐ no ☐
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 ☐

Hobbies, occupational exposures : _____

Any new food reactions? yes ☐ no ☐
If yes, please describe: _____

Insect sting reactions? yes ☐ no ☐ If yes, to which? bee, wasp, yellow jacket, hornet, fire ant, other: _____

Please describe: hives? difficulty breathing? throat swelling? Other: _____

Active 'eczema']? yes ☐ no ☐ If yes, current treatment _____

Medication reactions? yes ☐ no ☐ If yes, please describe: _____

Immunization reactions? yes ☐ no ☐ If yes, please describe: _____

Review of Systems: Please indicate your current, ongoing symptoms

Eye Symptoms	itching	☐	burning	☐	dark circles	☐	glaucoma	☐
none ☐	excessive tearing	☐	dryness	☐	wear contact lenses	☐	cataracts	☐

Ear Symptoms:	itching	☐	popping	☐	hearing loss	☐	frequent infections	☐
none ☐	pe tubes	☐	congested	☐	earache	☐	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	☐
none ☐	throat clearing	☐	postnasal drip	☐	other:	☐

Headache	under eyes	☐	forehead	☐	migraine	☐
none ☐	behind eyes	☐	temples	☐	other:	☐

Chest symptoms:	cough	☐	shortness of breath	☐	tightness	☐
none ☐	wheezing	☐	excessive mucous	☐	other:	☐

Abdominal:	heartburn	☐	frequent diarrhea	☐	frequent constipation	☐
none ☐	pain	☐	nausea / vomiting	☐	other:	☐

Skin symptoms:	hives	☐	itchy skin	☐	sensitivity to metals	☐
none ☐	swelling episodes	☐	eczema	☐	other:	☐

Cardiovascular	heart problems	☐	chest symptoms with exertion	☐
none ☐	hypertension	☐	other:	☐

Constitutional:	fever	☐	chills	☐	unexplained weight loss	☐
none ☐						

Musculoskeletal:	joint swelling	☐	stiffness or pain	☐	limb swelling or pain	☐
none ☐						

Neurological:	previous stroke	☐	other neurologic problems:	☐
none ☐				

Psychiatric:	emotional problems	☐	depression	☐	other:	☐
none ☐						

Are you using tobacco? Yes ☐ No ☐

<u>For patients with asthma:</u>

- Have you had any asthma 'attacks,' urgent care or ER visits, or hospitalizations for asthma in the past year? **yes ☐ no ☐** If yes, please explain: _____

- What is your current personal best peak flow? _____
- Do you have your ‘asthma action plan’ available? **yes** ☐ **no** ☐