

LIVE OAK ALLERGY & ASTHMA CLINIC

11515 TOEPPERWEIN RD, SUITE 202
LIVE OAK, TX 78233

PATIENT NAME: _____ AGE: _____ DATE: _____

REFERRED BY: _____ LIST OF MEDICATIONS: _____

| CHECK (✓) SYMPTOMS YOU HAVE HAD PAST OR PRESENT | | | | | |
|--|---------------------|--|----------------|--|-------------------|
| | NASAL | | BROKEN NOSE | | TROUBLE BREATHING |
| | SINUS | | ITCHY EYES | | WHEEZING |
| | STUFFY NOSE | | ITCHY NOSE | | CHEST TIGHTNESS |
| | WATERY NOSE | | ITCHY EARS | | FREQUENT COUGH |
| | SNEEZING | | ITCHY PALATE | | BRONCHITIS |
| | WATERY EYES | | LOSS OF SMELL | | ASTHMA |
| | PUFFY/SWOLLEN EYES | | LOSS OF TASTE | | PNEUMONIA |
| | FREQUENT HEADACHES | | EAR INFECTIONS | | |
| | POST NASAL DRAINAGE | | SINUSITIS | | |
| | FREQUENT RAW THROAT | | NASAL POLYPS | | |

| DO YOU RELATE ANY OF THE FOLLOWING TO YOUR NASAL (N) OR CHEST (C) PROBLEMS? MARK ("N") OR ("C") | | | | | |
|--|-----------------|--|-------------------------|--|----------|
| | SPRING | | FOODS | | ANIMALS |
| | SUMMER | | SMOKE | | GRASS |
| | FALL | | DUST | | WEEDS |
| | WINTER | | PERFUMES OR POWDERS | | FLOWERS |
| | WEATHER CHANGES | | COSMETICS (which ones): | | EXERCISE |
| | DAMPNESS | | | | LAUGHING |
| | CHILLING | | | | COUGHING |
| | BRIGHT SUN | | | | ANGER |

WHEN DID SYMPTOMS BEGIN? CHEST: _____ NASAL: _____

HAS IT EVER LIMITED ACTIVITY AT WORK? _____ SCHOOL? _____ HOME? _____

HAVE YOU LOST TIME AT WORK OR SCHOOL DUE TO ILLNESS? _____ WHEN? _____

HAVE YOU EVER BEEN SKIN TESTED BEFORE? YES () NO () WHEN? _____

WHAT WERE YOU ALLERGIC TO? _____

WERE YOU ON ALLERGY SHOTS? YES () NO () WHEN? _____

HAVE YOU EVER HAD THE HIVES ("WELTS")? _____ WHEN? _____

FROM WHAT? _____ HOW OFTEN? _____

DO YOU HAVE ANY PROBLEMS WITH ANY OF THE FOLLOWING? (Describe trouble)

MEDICINE: _____ OTHERS: _____ FOODS (which ones) _____

CONTACTANTS? _____ POISON IVY/OAK? _____ METALS? _____

DYES? _____ INSECT STINGS OR BITES? _____ ANTS? _____ BEES? _____

WASPS? _____ OTHERS? _____

DO YOU SMOKE? YES () NO () HOW MANY CIGARETTES/PACKS PER DAY? _____

HAVE YOU HAD ANY SERIOUS ILLNESSES? _____

DOES ANYONE IN YOUR FAMILY HAVE ANY ALLERGIES? (CHECK APPROPRIATE BOX)

| | HAY FEVER | ASTHMA | HIVES | SINUSITIS |
|-------------|------------------|---------------|--------------|------------------|
| Mother | | | | |
| Father | | | | |
| Sister(s) | | | | |
| Brother (s) | | | | |
| Children | | | | |