Dear Patient:

Please complete the enclosed questionnaire and bring it with you to the Clinic on the day of your appointment. If you have any questions, please feel free to contact us at (813) 974-2920.

Thank you
MEDICAL HISTORY AND ALLERGY SURVEY

Please complete this form. It is important for your doctor to know the details about your medical history and allergy symptoms. You may use the back of each page to complete your answers.

NAME ______________________________________ AGE ______ DATE _____________

Circle the allergy problems that you have:

(1) Hay fever/sinus (2) Asthma/bronchitis (3) Hives (4) Eczema (5) Insect allergy (6) Food allergy (7) Drug allergy (8) Headache

I. CLINICAL HISTORY

A. Describe your major allergy symptoms. How do they make you feel?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

B. What are your expectations from this allergy consultation?

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

II. SYMPTOMS (check)

Eye: Itching _____ Swelling _____ Burning _____ Tearing _____ Discharge ______

Ears: Itching _____ Fullness _____ Popping _____ Decreased Hearing _____ Pain ______

Nose: Sneezing _________ Itching _______ Runny nose _________ Mouth Breathing _________
Nasal obstruction _________ Discolored discharge _______ Snoring _________
Sense of smell impaired _________

Throat: Itching _______ Soreness _________ Post nasal drip _______Throat clearing _______ Swelling _________

Chest: Cough _______ Sputum _______ Color and amount _________
Wheezing _____ Chest _____ Tightness _____ Shortness of breath with exercise _________
History of asthma diagnosed by physician _________
Exercise-induced asthma _________
Nighttime wheezing _________

Skin: Dermatitis _____ Eczema _______ Hives _______ Swelling _____ Rashes _________
Where on your body? ____________________________________________

BP ___________ Pulse ___________
Weight ________ Height ________
(for medical staff completion)
A. Age of onset of your respiratory allergies (hay fever and asthma)
B. Do you have daily symptoms?
C. Do you have seasonal symptoms?
D. Are you having more allergy problems recently?
E. What time of the year are your allergies worse? (Please list months.)
F. What time of day or night is the worst time according to you?
G. Does any particular exposure (cat, dust, smoke) make you much worse? (Please list.)
H. Please list all food allergies.
I. Please list all drug allergies. (Please list name of drug, type of reaction, and approximate date of reaction.)
J. Have you had a life threatening allergic reaction to a stinging insect (bee, wasp, yellow jacket, hornet, fire ant)?
K. Have you had hives previously?
L. Have you had eczema (atopic dermatitis as an infant or child) previously?

III. PREVIOUS ALLERGY EVALUATION AND TREATMENT

A. Name of allergist and city
B. Please list your allergies
C. Have you received allergy shots?
   Were allergy shots beneficial?
   How long were you on allergy shots?
D. Is your home environment allergy-free?
E. Please list all recent medications prescribed or over-the-counter drugs you have used to treat your allergies.

Antihistamines for allergies (Benadryl, Tavist, Trinalin, Seldane, Hismanal, Claritin, Semprex-D, and others):
   improved __________ not improved ________ sedation ______

Bronchodilators for asthma - theophylline (Theo-Dur, Slo-Bid, Uniphyll) inhaled bronchodilators (Ventolin/Proventil, Maxair, Tornalate, Brethaire, Alupent, Serevent); and oral Ventolin/Proventil:
   How often do you use?
   improved __________ not improved ________ adverse reactions ______

Corticosteroids for hay fever or asthma - oral (prednisone); intranasal sprays (Vancenase, Beconase, Nasalide, Dexacort Turbine, Rhinocort intrabronchial (Vanceril, Beclovent, Aerobid, Azmacort):
   How often do you use?
   improved __________ not improved ________ adverse reactions ______

Last date on prednisone

Antibiotics for infections (sinusitis, bronchitis):
   Name __________________________ How often do you use?
   improved __________ not improved ________ adverse reactions (rash) ______

Last date on antibiotics ____________ Other treatment (Please list all medications that you take):
IV. PAST MEDICAL HISTORY

A. Please list all important operations and other significant hospitalizations that you have had, even if they are unrelated to your allergy problem.

B. Have you been hospitalized for asthma? _____ When? ________________
   Have you required emergency room visits or emergency treatment by your physician for asthma? _____

C. Do you have any current medical problems or a history of any medical problems?
   Diabetes _______ Thyroid disorder _______ High blood pressure _______ Seizures _______
   Arthritis _______ Hepatitis _______ Ulcers _______ Other _______

D. Have you ever had a blood transfusion? _______ When? ______________

E. Have you experienced recurrent sore throats, repeated sinus infections (how often?) _______________
   documented by x-ray? _______, or severe infections (what kind, kidney infection ____________),
   Meningitis _______ or pneumonia? _______), when?__________________

F. Have you had nasal polyps, adverse reaction to aspirin, or sinus surgery? ______________

G. Do you have any other symptoms or complaints (lack of energy, anxiety, or depression)? ______________

H. Please list all your prescribed and over-the-counter medications (include aspirin, laxatives, sleeping medication).
   ____________________________________________________________________________

I. Have you had a chest x-ray, sinus x-ray, lung function tests, EKG, blood tests? Please comment on the results.
   ____________________________________________________________________________

J. Are your vaccinations up to date? ___________ Tetanus? (every 10 years) _________

K. Do you receive the flu vaccine yearly? ________________

L. Have you received the pneumovax (for pneumonia)? ________________
V. REVIEW OF SYSTEMS

Do you have any of the following? (Check)

<table>
<thead>
<tr>
<th>General</th>
<th>Blood</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ weight loss</td>
<td>_____ had anemia</td>
</tr>
<tr>
<td>_____ chills</td>
<td>_____ bleed or bruise easily</td>
</tr>
<tr>
<td>_____ fevers</td>
<td>_____ swollen lymph nodes</td>
</tr>
<tr>
<td>_____ loss of appetite</td>
<td></td>
</tr>
<tr>
<td>_____ dry mouth</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Eyes and Ears</th>
<th>Musculoskeletal</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ dry eyes</td>
<td>_____ Morning joint stiffness and aching</td>
</tr>
<tr>
<td>_____ change in vision</td>
<td>_____ painful, swollen joints</td>
</tr>
<tr>
<td>_____ Trouble hearing</td>
<td>_____ muscle tenderness or pain</td>
</tr>
<tr>
<td>_____ ringing in ears</td>
<td>_____ muscle weakness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Skin</th>
<th>Endocrine</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ skin rashes</td>
<td>_____ cold intolerance</td>
</tr>
<tr>
<td>_____ recurrent skin infections</td>
<td>_____ heat intolerance</td>
</tr>
<tr>
<td></td>
<td>_____ increased thirst</td>
</tr>
<tr>
<td></td>
<td>_____ frequent urinations</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Gastrointestinal</th>
<th>Gynecological</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ nausea</td>
<td>_____ excess bleeding</td>
</tr>
<tr>
<td>_____ vomiting</td>
<td>_____ vaginal discharge</td>
</tr>
<tr>
<td>_____ diarrhea</td>
<td>_____ change in menstrual cycle</td>
</tr>
<tr>
<td>_____ change in bowel habits</td>
<td></td>
</tr>
<tr>
<td>_____ trouble swallowing</td>
<td></td>
</tr>
<tr>
<td>_____ heartburn</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Cardiovascular</th>
<th>Psychological</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ chest pain</td>
<td>_____ fearful, anxious</td>
</tr>
<tr>
<td>_____ chest pain with exercise</td>
<td>_____ excessive worry</td>
</tr>
<tr>
<td>_____ calf pain with exercise</td>
<td>_____ crying spells</td>
</tr>
<tr>
<td>_____ ankle swelling</td>
<td>_____ trouble sleeping</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Kidney</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>_____ trouble starting urine</td>
<td>_____ lumps or bumps under arms, breasts</td>
</tr>
<tr>
<td>_____ bed wetting</td>
<td>_____ skin rashes in the groin</td>
</tr>
<tr>
<td>_____ burning with urination</td>
<td>_____ skin rashes between legs</td>
</tr>
<tr>
<td>_____ loss of urine with cough or sneeze</td>
<td>_____ skin rashes on the toes</td>
</tr>
<tr>
<td>_____ frequent urination during the night</td>
<td>_____ skin rashes on the feet</td>
</tr>
</tbody>
</table>

VI. ENVIRONMENTAL HISTORY

A. Do your symptoms occur around any specific environment, exposure, location, or activity (for example, lawn mowing, animals, dusty environments, old leaves, strong odors, exercise)?  
B. Do you suspect that anything in your home, work place, or other locations cause your symptoms?  
C. What type of home do you have and what is the surrounding area like (suburbs; country)?  
D. Do you have indoor animals or birds? Please list.  
E. Do you have a feather, foam, or Dacron-pillow?  
F. Do you have a new or old mattress?  
G. Do you have wall-to-wall carpeting throughout your home?
H. Are your windows opened or closed most of the time?

I. Do you have central air conditioning?

J. Does air conditioning help your symptoms?

K. Do your symptoms become better or worse on vacations, trips, or at the beach?

L. Do you have symptoms after eating at home or in a restaurant?

M. Does a change in the weather influence your allergic symptoms?

M. Do strong odors, powders, fumes, cigarette smoke make you worse?

N. How do strenuous activities affect your symptoms?

VII. PERSONAL AND SOCIAL HISTORY

A. Do you presently smoke (how much and how long)?

B. Have you ever smoked and when did you quit?

C. How much alcohol do you drink?

D. Do you use recreational drugs? (This is confidential.)

E. Do you consider yourself at risk for HIV?

F. What is your occupation?
   What are your daily activities?
   How many days have you missed from work or school?

G. Are you exposed to any toxic chemicals, noxious substances, or cigarette smoke?

H. How long have you lived in Tampa and/or Florida?

I. Where have you lived previously?

J. Are you happy with your life? If not, why?

K. How many other people live in your home?
   Do any of them smoke?

VIII. FAMILY HISTORY

A. Are there any members of the immediate family who have asthma, hay fever, eczema, hives, food allergies, drug allergies, insect allergies, arthritis, recurring and/or frequent infections? Please list and comment.

B. Are there any hereditary diseases or other disorders that seem to occur frequently in your family (diabetes, emphysema, heart problems)?