Allergy & Asthma Consultants, L.L.P.

720 W.34th Street • Suite 200•Austin, Texas 78705

Office (512) 454-5821•Fax (512) 459-9137

Date: _____ **Print Name: _____**

Referring Physician: _____

Reason for Visit: _____

_____

_____

_____

_____

Check Symptoms You Have or Have Had:

Nasal Symptoms
- ❑ Frequent sneezing
- ❑ Runny nose
- ❑ Nasal congestion
- ❑ Nose bleeds
- ❑ Loss of smell
- ❑ Nasal polyps

Sinus Symptoms
- ❑ Frequent infections
- ❑ Pressure in cheeks
- ❑ Pressure around eyes
- ❑ Post nasal drip
- ❑ Prior sinus surgery

Eye Symptoms
- ❑ Itching
- ❑ Burning
- ❑ Redness
- ❑ Swelling of eyelids
- ❑ Matting

Ear Symptoms
- ❑ Pain
- ❑ Itching
- ❑ Plugging
- ❑ Loss of hearing
- ❑ Ringing

Respiratory Symptoms
- ❑ Asthma
- ❑ Wheezing
- ❑ Coughing
- ❑ Productive cough
- ❑ Dry cough
- ❑ Night-time cough
- ❑ Exercise-induced wheezing
- ❑ Exercise-induced cough
- ❑ Chest tightness
- ❑ Anything relieve the chest tightness? _____
- ❑ Aspirin worsen asthma

Abdominal Symptoms
- ❑ Weight loss
- ❑ Heartburn or reflux
- ❑ Frequent diarrhea
- ❑ Known food allergies

List:_____
_____
_____
_____

Skin Complaints
- ❑ Childhood eczema
- ❑ Hives
- ❑ Contact rash
- ❑ Itching

Headache Pains
- ❑ Sinus
- ❑ Migraine
- ❑ Tension
- ❑ Associated with menses

Location
- ❑ Frontal
- ❑ Temporal Area

  Other site: _____

Frequency
- ❑ Daily
- ❑ Occasionally
- ❑ Seldom

Other Serious Infections
- ❑ Ear infections
- ❑ Pneumonia
- ❑ Skin
- ❑ Meningitis

Stinging Insect Reactions
- ❑ Large local reactions
- ❑ Anaphylaxis

  Type of insect: _____

Are Your Symptoms Worse:
- ❑ At home
- ❑ At work
- ❑ Out doors
- ❑ Around smoke
- ❑ Around fumes
- ❑ In the winter
- ❑ In the spring
- ❑ In the summer
- ❑ In the fall
- ❑ With any activity

  List:

  _____

  _____

Prepared by EJ Peters, MD, PA

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Environmental and Social History:

What is your occupation?_____

What type of home do you live in? Single-family home: ❑ Apartment: ❑ Farm or ranch: ❑

Do you have carpets in the bedrooms? Yes ❑ No ❑

Do you have feather pillows? Yes ❑ No ❑

Do you exercise regularly? Daily: ❑ Occasionally: ❑

Type of exercise: _____

Exposure History:

Any unusual work exposures:_____

Any unusual hobbies or sports: _____

Do you have any pets? Dogs _____ Cats _____ Other _____

Do the pets live indoors? Yes ❑ No ❑

Do the pets sleep in the bedroom? Yes ❑ No ❑

Does exposure to any pets increase your symptoms? Yes ❑ No ❑

Medical History:

Primary Care Physician: _____

Have you ever had previous allergy testing? Yes ❑ No ❑

If so, when? _____

Have you seen an ear, nose, and throat (ENT) physician? Yes ❑ No ❑

Have you had an adenoidectomy? Yes ❑ No ❑

Have you had a tonsillectomy? Yes ❑ No ❑

Any history of injury to your face or nose? Yes ❑ No ❑

Have you had any other surgeries? Yes ❑ No ❑

Please list: _____

Have you had a recent chest x-ray? Yes ❑ No ❑

Date: _____

Have you had a recent sinus CAT scan or x-ray? Yes ❑ No ❑

Date: _____

Do you smoke? Yes ❑ No ❑

If so, how many packs: _____

Have you ever smoked? Yes ❑ No ❑

If so, how long did you smoke: _____

Medication History:

Present medications (please list medicine and dose if possible):

_____

_____

Any known medication allergies? Yes ❑ No ❑

If so, please list with reaction: _____

Family History:

	Grand-Parents	Father	Mother	Brother	Sister	Children
Asthma	❑	❑	❑	❑	❑	❑
Allergies	❑	❑	❑	❑	❑	❑
Eczema	❑	❑	❑	❑	❑	❑
Insect Allergies	❑	❑	❑	❑	❑	❑
Food Allergies	❑	❑	❑	❑	❑	❑
Hives	❑	❑	❑	❑	❑	❑
Chronic Obstructive Pulmonary Disease (COPD)	❑	❑	❑	❑	❑	❑