Family History

1. Do any members of the family have hay fever, asthma, eczema, hives, migraine headaches, allergic stomach, sinus trouble, or frequent bronchitis? Mother_____Father_____
Brothers_____Sisters_____Children_____

Habits

1. Do you smoke?_____How much?_____
2. Has an alcoholic beverage ever aggravated your symptoms?_____
3. List hobbies such as ceramics, yard work, woodworking, fly-tying, jogging, etc. _____
_____

Review of Systems

1. Have you had an previous allergy studies?_____Where?_____
2. Hyposensitization shots?_____How long?_____
3. Have you had other problems with the following:
   - Heart_____Bowel_____
   - Kidneys_____Brain or spinal cord_____
   - Bones_____Lungs_____
   - Stomach_____Blood pressure_____

Can you think of anything else that may help us with your diagnosis?_____
_____
_____
_____

List all medications you are now taking

	Drug	Dose	Frequency	Comment
1.				
2.				
3.				
4.				
5.				

Who is your primary care physician?_____
Did this physician refer you?____If not, who did?_____

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