

Asthma, Allergy and Immunology Review

Name _____ Age _____
 Occupation _____
 Date _____ Referred by (if any): _____

Patient Name: _____
 Record #: _____ HB: _____

Antihistamine medications (Claritin, Allegra, Zyrtec, Benadryl, Atarax, Contac, etc.) may interfere with skin tests for specific allergies; _____ . **You need not stop other medications.**

Please answer all questions on all four pages to the best of your ability. Base your answers on your own observations and not what you have been told by others or what you may have presumed on the basis of previous allergy tests. Complete the questionnaire before you see the Physician as the information will organize your thinking and facilitate understanding of your case.

I. Describe in your own words your problem(s) which might reflect an allergic/exaggerated reaction: _____

II. Check the boxes and complete the blanks which apply to your symptoms:

	Present Problem	Past Problem	<u>Physician Comment</u>
A. Eye symptoms: (Wear contacts <input type="checkbox"/>)			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Watering	<input type="checkbox"/>	<input type="checkbox"/>	
Redness	<input type="checkbox"/>	<input type="checkbox"/>	
Swelling	<input type="checkbox"/>	<input type="checkbox"/>	
Burning	<input type="checkbox"/>	<input type="checkbox"/>	
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	
Foreign Body Sensation	<input type="checkbox"/>	<input type="checkbox"/>	
B. Symptoms in the upper respiratory tract (nose, sinuses, throat, eustachian tubes, voice box)?			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Sneezing	<input type="checkbox"/>	<input type="checkbox"/>	
Congestion	<input type="checkbox"/>	<input type="checkbox"/>	
Headache	<input type="checkbox"/>	<input type="checkbox"/>	
Obstruction	<input type="checkbox"/>	<input type="checkbox"/>	
Drainage	<input type="checkbox"/>	<input type="checkbox"/>	
Soreness	<input type="checkbox"/>	<input type="checkbox"/>	
Dryness	<input type="checkbox"/>	<input type="checkbox"/>	
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	
Polyps	<input type="checkbox"/>	<input type="checkbox"/>	
Impaired Smell/Taste	<input type="checkbox"/>	<input type="checkbox"/>	
Snoring	<input type="checkbox"/>	<input type="checkbox"/>	
C. Symptoms in the lower respiratory tract (windpipe, bronchi, lungs):			
Itching	<input type="checkbox"/>	<input type="checkbox"/>	
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	
Sputum production	<input type="checkbox"/>	<input type="checkbox"/>	
Tightness-Congestion	<input type="checkbox"/>	<input type="checkbox"/>	
Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	
Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	
Pain	<input type="checkbox"/>	<input type="checkbox"/>	

How many ordinary colds and 'flu' illnesses have you had in the past year? # _____

How many colds and 'flu' on average in the last 5 years? # _____ /yr.

What proportion (0, 10, 25, 50, 75, 90, 100%) of these are complicated by: Otitis - earache, decreased hearing _____ %; Sinusitis - pressure, discolored drainage _____ % Bronchitis - cough with discolored sputum _____ % Asthma - chest tightness, wheeziness _____ %.

What proportion (0, 10, 25, 50, 75, 90, 100%) require antibiotics for resolution? _____ %

Which antibiotic(s) work(s) best for you? _____

	Present Problem	Past Problem	Physician Comment
D. Symptoms (check) in the stomach and digestive system which you suspect might be allergic?			
Pain or difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	
Nausea or vomiting	<input type="checkbox"/>	<input type="checkbox"/>	
Heartburn/Indigestion	<input type="checkbox"/>	<input type="checkbox"/>	
Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>	
Constipation/Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	
E. <input type="checkbox"/> Hives <input type="checkbox"/> Giant swelling (Check)	<input type="checkbox"/>	<input type="checkbox"/>	
F. <input type="checkbox"/> Eczema?	<input type="checkbox"/>	<input type="checkbox"/>	
G. Skin reaction to <input type="checkbox"/> poison ivy/oak <input type="checkbox"/> metals <input type="checkbox"/> chemicals or <input type="checkbox"/> cosmetics? (check)	<input type="checkbox"/>	<input type="checkbox"/>	
H. Reaction to <input type="checkbox"/> bee <input type="checkbox"/> hornet <input type="checkbox"/> wasp <input type="checkbox"/> yellow jacket sting or <input type="checkbox"/> other stinging insect sting? (check)	<input type="checkbox"/>	<input type="checkbox"/>	
I. Reaction to immunizations?	<input type="checkbox"/>	<input type="checkbox"/>	
J. Reaction to drug?	<input type="checkbox"/>	<input type="checkbox"/>	
Penicillin (date/year last taken _____)	<input type="checkbox"/>	<input type="checkbox"/>	
Aspirin (date/year last taken _____)	<input type="checkbox"/>	<input type="checkbox"/>	
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>	
Nose drops/sprays	<input type="checkbox"/>	<input type="checkbox"/>	
Sedatives	<input type="checkbox"/>	<input type="checkbox"/>	
Pain relievers	<input type="checkbox"/>	<input type="checkbox"/>	
Hormones	<input type="checkbox"/>	<input type="checkbox"/>	
Antihistamines	<input type="checkbox"/>	<input type="checkbox"/>	
Cortisone	<input type="checkbox"/>	<input type="checkbox"/>	
X-ray dye	<input type="checkbox"/>	<input type="checkbox"/>	
Others _____	<input type="checkbox"/>	<input type="checkbox"/>	
K. <input type="checkbox"/> Sleep disruption and or <input type="checkbox"/> fatigue? (check)	<input type="checkbox"/>	<input type="checkbox"/>	

III. Check or complete the correct answers to describe your residence and workplace.

Type of Dwelling:

- House Apartment Condominium Dormitory Mobile /Motorhome

Location of Dwelling:

- Seashore City Country Mountain Desert

Age of Dwelling _____ years Years of occupancy _____ Obvious mildew/moldspore Roaches

Central: Heating Air Conditioning Humidifier Filter-type _____

Bedroom: Heating Air Conditioning Humidifier Filter-type _____

Bedroom Floor Coverings: Carpet Wood Cement Linoleum/tile

Bed mattress: Conventional Water Age in years _____ Allergen Encasement

Pillows: Feather/Down Foam rubber Dacron/Synthetic Age in years _____

Indoor Animals: Cat Dog Bird Other _____

Outdoor Animals: Cat Dog Horse Other _____

Smoker(s) in residence: Relationship _____

Describe briefly your workplace/school environment _____

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IV. Check appropriate box for symptoms aggravated or precipitated by exposure or during:

	Eyes	Nose/ Sinuses/ Ears	Chest	Digestive	Hives/ Swelling	Eczema
Spring (March-April-May)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Summer (June-July-August)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Autumn (Sept-Oct-Nov)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Winter (Dec-Jan-Feb)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sleep	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
On awakening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
At play	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Vacation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emotional upset - laughter, anger	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Weather changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dampness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cold	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air Conditioning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sunlight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Irritant fumes/aerosols/sprays	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Smog	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetics/perfumes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco smoke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Newsprint	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
House dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Road dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dogs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Birds/feathers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other animal(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Egg	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Milk/dairy products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Wheat/wheat products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Corn/corn products	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Strawberries/other berries: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Peanut/other nut: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Shrimp/lobster/other seafood: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fish	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Dried fruits	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Restaurant meals	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Beer/wine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chocolate	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other food(s): _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Menstrual cycle	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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V. Complete the blanks or check characteristics to describe yourself:

of days at work/school missed in past year? _____ # of practitioners seen in past year? _____
 # of emergency room/urgent care visits in past year? _____ # of days in hospital in past year? _____
 Aerobic exercise type? _____ Hours per week? _____
 Average hours of sleep per night when well? _____ When ill? _____
 Packs of cigarettes smoked per day? _____ Other tobacco per week? _____
 Bottles of beer per week? _____ Alcoholic drinks per week? _____

Hobbies _____

Marital/family adjustment: Difficult Average Easy
 Self/spouse/parent/child/significant other - alcohol or chemical dependency? Yes No
 Work/school adjustment: Difficult Average Easy
 Financial problems: Major Average Little
 Tendency to worry/anxiety/panic: Strong Average Little
 Depression: Strong Average Little

VI. Family History of Allergy:

	Eyes	Nose/ Sinuses/	Chest	Digestive	Hives/ Swelling	Eczema
Mother	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Father	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Siblings	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

VII. Treatment:

	Received	Helpful	Side Effects
Antihistamine by mouth _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Decongestants by mouth _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nasal sprays/drops _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Oral bronchodilators _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inhaled bronchial medications _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Antibiotics _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pollen, mold, dust, injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Steroids - Circle: (nose/bronchial/pills/injection)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Food elimination	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Education about allergies _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Year of last immunization for influenza? _____ pneumonia? _____ tetanus? _____ measles? _____

 Patient/Parent Signature/Date

Physician Comments (Check on basis of history)

- Conjunctivitis:
 - IgE* Irritant Contacts Giant Papillary (GPC) Vernal Delayed contact sensitivity
- Rhinitis/Sinusitis:
 - IgE* Vasomotor Polyps Muroid Purulent Medicamentosa Atrophic Irritants
- Asthma/Bronchitis/Cough:
 - IgE* Irritants Meteorologic Emotional Respiratory infection Exercise Aspirin
 - Sulfite Occupation Inhaler overuse Muroid impaction COPD CHF Esophageal reflux
 - Psychologic factors Laryngeal dysfunction Other _____
- Urticaria/Angioedema:
 - Sporadic Chronic Food Drug Exercise Heat Cold Light
 - Emotional Infection Neoplasm CT Disorder Familial
- Pruritis/Eczema:
 - IgE* Delayed contact sensitivity Irritant Neurodermatitis Other _____
- Stinging Insect:
 - IgE - Life threatening anaphylactic Other IgE Non IgE
- Drug Reaction:
 - _____ IgE Other immunologic Non-immunologic
- Systemic Anaphylactic/toid:
 - IgE _____ Exercise Spontaneous Other _____

*IgE suspected to (check) tree grass weed dander mite spore food Other _____