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ALLERGY EVALUATION

ROYAL PALM BEACH MEDICAL GrOUP

Dr. Lipson has referred you to be evaluated and possibly tested for allergies in his office.

Paula Gadomski will be contacting you to schedule an appointment once she receives Authorization from your insurance company.

Please remember to bring the attached Allergy questionnaire along with your insurance cards to your appointment.

Do not take any Antihistamines, Cold Tablets or Cough Syrup 24 hours prior to testing.

If you have any further questions or concerns, please contact Paula Gadomski

@

561-430-5900

Or

paula@symptacorp.com

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To Be Completed By Patient

sympta.

NAME: DATE:

1. What is your principal reason for consulting us?

2. Circle any of the following that you have had:

Sneezing	Runny nose	Stuffy nose	Sinus congestion
Phlegm	Headaches	Watery eyes	Post-nasal drip
Cough	Wheezing	Tight chest	Short of breath
Eczema	Skin rash	Hives	Swellings
Hay fever	Poison ivy	Hoarseness	Bee sting reaction
Asthma	Bronchitis	Ear blockage	Ear infections
Sinusitis	Nasal polyps		Frequent colds
Pneumonia	Loss of smell		Skin infections

3. Underline the months that you have symptoms; circle the worst ones:

JAN FEB MAR APR MAY JUN JUL AUG SEP OCT NOV DEC ALL THE SAME

4. On the average, how often do you have symptoms?

DAILY WEEKLY MONTHLY 2-3 TIMES A MONTH ALL THE SAME

5. How long ago, or at what age, did you first have symptoms?.

6. Circle any of the following which seem to cause your symptoms:

Cat	Barns	Air conditioning
Dog	Musty areas	Cold air
Horse	Basements	Exercise
Birds	Tobacco smoke	Weather changes
Other animals	Perfume	Warmth
Mowing grass	Other fumes	Humid weather
Raking leaves	Alcohol	Work environment
Dusting	Viruses or colds	Emotional stress
Foods:		

7. Circle what describes your home environment:

Dry	Urban	Suburban	Rural
Damp	Pillows:	feather, foam,	polyester
Musty	Heat:	air, water,	steam
Dusty		oil, gas, wood,	coal

8. Do you have pets? NONE DOG CAT BIRD OTHER:

9. What kind of work do you do?

Are your symptoms different at work? BETTER WORSE SAME

10. Had you ever had allergy skin tests? YES NO
If so, when and by whom?
Do you know any positive results?

11. Were you ever treated with allergy injections? YES NO

12. What, if anything, usually relieves your symptoms?

13. Have you ever lived in or visited other areas where your symptoms were better or worse? If so, where?

14. What medications have you taken for these symptoms?

What are you taking now?

Do they help? YES NO SOMEWHAT

Have you used nose sprays? YES NO

Have you ever taken cortisone (Prednisone, Medrol, etc.)?
If so, when was the last time?

15. List all the medications that you are taking presently:
(including Vitamins, Birth control pills, etc.)

16. Are you allergic or sensitive to any medications?
If so, name the medication and what kind of reaction.

17. Were your childhood immunizations completed for diptheria, tetanus, Whooping cough, Measles, Mumps, Rubella, Polio?

18. Have you ever had any reactions to any immunizations or vaccination?
YES NO If so, which one?

19. Have you ever had flu shots? YES NO
Have you ever had pneumonia vaccine (Pneumovax)? YES NO

20. When was you last TB test?
Was it positive or negative?

21. <u>Circle any of these that you have had:</u>

Scarlet Fever	Diabetes	Cancer
Rheumatic Fever	High blood pressure	TB
Hepatitis	Heart attack	Mono
Heart murmur	Tonsilectomy	Arthritis
Nasal surgery	Heartburn	Stroke
		Ulcers

Other surgery:

22. Have you ever been a smoker? YES NO When did you quit?
How many packs per day? How many years?

23. Does anyone in your immediate family suffer from allergies?
HAY FEVER ASTHMA ECZEMA HIVES

24. How have you been recently?

ANSWER THE FOLLOWING ONLY IF YOU HAVE HAD ASTHMA OR WHEEZING

25. How often do you wheeze? All the time Several times per:
DAY WEEK MONTH YEAR

26. How long does it usually last? MINUTES HOURS DAYS

27. When was your last bout of wheezing?

28. Have you been treated in hospital emergency rooms? YES NO
If so, how many times in the past year?

29. Circle any of the following which seem to cause or aggravate your wheezing:

Infections	Animals	Work area
Colds	Smoke	Emotional stress
Cold air	Fumes	Weather changes
Exertion	Seasons: SUM-FALL-WIN-SPR	

Food(s) : Medicines:

30. Have you had any reactions to asthma medicines?

31. Have you been treated with any of the following:

Theophyllines (any brand)
Inhalers (Primatene, Isuprel, Bronkometer, Alupent, Metaprel, Ventolin, Proventil)
Beclomethasone (Vanceril, Beclovent)
Cromolyn (Intal spinhaler)

32. When was your last chest X-ray?

33. Have you ever had Pulmonary Function Tests (breathing tests) perfomed at a hospital?

34. Have you ever had tuberculosis (TB)?

URTICARIA HISTORY QUESTIONNAIRE

NAME: DATE:

1. Do you have "hives" (itchy bumps or welts) or swelling of areas of skin or both? HIVES SWELLING BOTH
   Underline which you have; circle which occurs the most.

2. How often do they occur?
   EVERY DAY: SEVERAL TIMES PER: WEEK MONTH YEAR

3. How long have you had this problem?

4. Have you ever had this problem before?

5. About how long will an average individual hive last?
   MINUTES HOURS A DAY DAYS

6. Do they: ITCH BURN HURT PRICKLE

7. Where do they occur?

HANDS	FACE	CHEST	ARMS
FEET	LIPS	ABDOMEN	LEGS
SCALP	EARS	BACK	THROAT

8. Do you have any associated symptoms:

FLUSHING	DIFFICULTY BREATHING	WHEEZING
STOMACH PAIN	DIFFICULTY SWALLOWING	HEADACHE
DIARRHEA	JOINT PAIN	JOINT SWELLING

9. Have you noted or suspected any obvious causes?

10. Circle any of the following which seem to cause or worsen your symptoms:

HEAT	VIBRATION	PERSPIRATION	WOOL	WORKPLACE
COLD	PRESSURE	EMOTIONAL STRESS		ALCOHOL
RUBBING	SUNLIGHT	MENSTRUAL PERIOD	METAL	ANIMALS
	EXERTION	MEDICINES		ASPIRIN
SEASON:	SUM-FALL-WIN-SPR		FOODS	COSMETICS

11. Were any of the following new or different about the time or shortly before this problem started?

PETS	LAUNDRY DETERGENT	JOB	DIET
CLOTHING	FABRIC SOFTENER	INSULATION	
HOUSE	HOME FURNISHINGS	BATH SOAP	

Asthma Screening Questions

Patient Name _____ Date _____

Telephone _____ MD/RN _____

Are you sleeping through the night without coughing, wheezing, or shortness of breath?

How often are you having to get up and use your bronchodilator at night?

How many times a week do you wake up coughing or wheezing?

Does your oral asthma medicine seem to keep you awake at night?

How long does your bronchodilator inhaler normally last?

Does your asthma prevent you from leaving your home, or engaging in certain activities?

Has your asthma kept you from attending work or school?

Are your activities of daily living or ability to exercise affected by your asthma? (Stair climbing, housework, hobbies, gardening)

How do you feel your asthma symptoms are controlled overall? (Fair, good, very good)