

Allergy & Asthma Center, P.C.

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Patient Name			
Date of Birth		Date	

Briefly describe reason for allergy visit: _____

Have you ever had the following conditions? (Write YES or NO for each item):

	Present problem	Past problem	Age at onset	Mild: 1-2 days/week	Moderate: 2-5 days/week	Severe: 5+ days/week
Runny nose or itchy nose						
Sneezing						
Itchy eyes						
Stuffy or congested nose						
Sinus problems						
Wheezing						
Persistent coughing						
Chest tightness						
Shortness of breath						
Bronchitis or prolonged coughing with "colds"						
Pneumonia						
Emergency room visit or hospitalization for breathing problems						

Check any symptoms that occur after vigorous exertion or exercise:

- coughing wheezing chest tightness throat clearing

Are your symptoms worse during certain months of the year? Yes No

Which months? _____

If yes, do you have mild symptoms year around? Yes No, am well rest of the year

Check any conditions that make your symptoms worse:

- | | |
|---|--|
| <input type="checkbox"/> mowing the lawn, exposure to cut grass, playing in grass | <input type="checkbox"/> raking leaves |
| <input type="checkbox"/> sweeping, dusting, using vacuum cleaner | <input type="checkbox"/> being around animals or the places where animals live |
| <input type="checkbox"/> tobacco smoke or other fumes | <input type="checkbox"/> strong odors or perfumes |
| <input type="checkbox"/> moldy or mildewed areas | <input type="checkbox"/> other (specify below) |

Specify: _____

BEE STING (honey bee, yellow jacket, hornet, wasp):

Date of sting(s) _____

I had the following reaction: large local swelling around the sting only trouble breathing

hives or swelling on other parts of my body vomiting feeling faint

FOOD REACTION:

I have had reactions to the following food(s): milk eggs fish peanut nuts

other (specify) _____

I get the following symptoms from these foods: stomachache loose bowels (diarrhea) nausea

rash stuffy nose asthma other (specify) _____

Patient's Name _____ Birthdate ____/____/____

ENVIRONMENTAL HISTORY:

Geographic history:

Where were you born? _____
In what state (country) did you spend most of your life? _____
How long have you lived in Oregon? _____

Home environment:

Type of heating: _____
How old is your mattress? _____ pillow? _____ check if waterbed
 Yes No Is your pillow covered with zip-on hypoallergenic covers? Yes No Synthetic
 Yes No Do you have a feather comforter?
 Yes No Is there carpeting in your bedroom? How old is it? _____
 Yes No Does your house have dampness, mold, or mildew problems?
How old is your home? _____ How long have you lived there? _____
Is it an apartment? _____ Is it a manufactured home? _____
How many pets come inside your home (specify number)?
_____ dogs _____ cats _____ other (specify) _____
 Yes No Do you have horses or other outside animals?
Specify: _____

Lifestyle history:

Yes No Have you ever smoked or vaped? Date quit _____
 Yes No Do you presently smoke or vaped?
How many years have you or did you smoke or vape? _____
How many packs (average) per day? _____
 Yes No Does anyone else in the home smoke or vape? Who?
 Yes No Do you use alcohol? How much/how often?
 Yes No Do you use recreational drugs? What? _____
 Yes No Do you have an Advance Directive?

Occupational history:

What type of work do you do? _____

Do you use over-the-counter nose sprays? Yes No Occasionally Regularly

Have you ever received a corticosteroid (cortisone) injection for allergies? Yes No

Have you had sinus surgery? Yes No Date _____

Date of last chest x-ray: _____ Date of last sinus CAT scan: _____

Review of Systems: Have you ever had any of the following? Circle or check all that apply:

- | | | |
|---------------------------------|---------------------|-------------------------------|
| Frequent headaches | High blood pressure | Stomach or digestive problems |
| Ear infections/Sinus infections | Thyroid problems | Kidney trouble |
| Glaucoma/Cataracts | Skin problems | Liver trouble |
| Heart trouble | Tuberculosis | Neurological problems |
| Psychiatric | Diabetes | |

Family Health:

Yes No Is there a history of allergy in your family? If yes, please indicate:

	Allergies	Hay fever	Asthma	Sinus problems	Eczema	Hives
Parents						
Siblings						