Dr. ARTHUR LUBITZ, *Allergist*
Dr. AMA ALEXIS, *Allergist*

Symptom Analysis

Name: ______________________________ Age: __________ Sex: M F (circle one) Date: ______ /______ /______

Referring Physician (to whom reports may be sent)

Name: ______________________________

Address: ______________________________ City: ______________

State: ______________ Zip: ______________ Phone: (______) ______-______ x ______

Email: ______________________________

Why are you seeing us? (please describe)

____

____

____

Do you have any of these?

Yes	No		Yes	No	
☐	☐	Snoring	☐	☐	Past hospitalization for asthma
☐	☐	Coughing	☐	☐	Possible reaction to food or drug
☐	☐	Frequent sneezing	☐	☐	Wheezing or shortness of breath
☐	☐	Diagnosis of asthma	☐	☐	Nasal congestion and/or runny nose
☐	☐	Frequent headache	☐	☐	Drainage down back of throat
☐	☐	Bee sting reactions	☐	☐	Frequent sinus infections/bronchitis
☐	☐	Rashes or eczema	☐	☐	Frequent yellow or green nasal drainage
☐	☐	Itchy or watery eyes			

Symptoms occur most often:

- ☐ Spring
- ☐ Summer
- ☐ Autumn
- ☐ Winter
- ☐ Year round

Symptoms worsen/change with:

☐ Aerosols sprays	☐ Cold air	☐ Colds/flu
☐ Cosmetics	☐ Cigarette smoke	☐ Pets (cat, dog, bird, other)
☐ Plants (poison ivy)	☐ Chemicals	☐ Fresh cut grass
☐ Dusting or cleaning		

List your current medications:

____

____

Tell us about your home environment:

Type of house/apt floor: ______________________________ Length of occupancy: ______________

Heat: ☐ Radiator ☐ Central ☐ Hot Water A/C: ☐ Central ☐ Window ☐ None

Humidifier: (central/separate units) ______________________________ Dampness/musty areas: ☐ Yes ☐ No

Bedroom: (Type of comforter/duvet:) ______________________________ (Type of pillows): ☐ Feather ☐ Foam

(Type of blankets): ______________________________ (Type of flooring): ______________

Living area (Type of flooring): ______________________________

Type and Number of Pets: ______________________________ Bedroom pets: ______________

Previous Pets: ______________________________ Mice/Roaches: ☐ Yes ☐ No

Hospital visits/Surgeries: ______________________________

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Immunization Status: Are your vaccines up-to-date? ☐ Yes ☐ No

Past Allergy Care: ______________________________

Do you have allergic reactions to:

☐ Aspirin	☐ Latex rubber	☐ Insect stings	☐ Other:
☐ Sulfites	☐ Food & additives	☐ Plants	______________
☐ Medications	☐ Vaccines	☐ Soaps/fabric softeners/ cosmetics	______________

Family History: (Parents) ______________ (Siblings) ______________ (Other) ______________

Social & Work History - Occupation: ______________________________

Work exposure: ______________________________ Skin sensitivities: ______________

Sensitivity to chemicals/smells/newspapers: ______________ Alcohol usage: ______________ Drug usage: ______________

Tobacco history: ______________ Please desribe: ______________________________

Secondary tacbacco exposure: