New Patient Questionnaire For Allergy & Sensitivity Symptoms

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Gender: male / female</th>
<th>Date:</th>
<th>Address:</th>
<th>Date of Birth:</th>
<th>Home#:</th>
<th>Work#</th>
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Referring Physician, Person or media that referred you to us?

Primary Care Physician: ____________ Allergist: ____________

Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:

- *We do not treat symptoms or diseases.*
- *Allergy is not a disease, rather a condition.*
- *A symptom is an attempt by your body to tell you something.*
- *We will attempt to find the underlying cause.*
- *We do not use drugs in this program, however nutrition or homeopathic might be recommended.*
- *There is no single “healthy” diet that will work for everyone.*
- *Just because food is considered “healthy”, does not mean it is “healthy” for you.*
- *Your diet consists of everything you eat, drink, rub on your skin, or inhale.*
- *Our procedures are safe and painless.*

Briefly describe the reason for your visit and what you hope to accomplish: ______________________________

Please finish this statement: “My symptoms started ever since ________________________________”

1. Your age now: _______ Your age when symptoms were first observed: ______________________________

2. Did you suffer from or did you observe someone else suffering from, any type of physical, chemical or emotional trauma days or months before the symptoms were first observed? (auto accident, divorce (you or parent), home relocation, college) ___________________________________________

3. Have your symptoms ever gone away for a period of time? __________________________________________

4. What state or country did you first notice the symptoms? __________________________________________

5. Have you ever traveled out of the country or to an island? _________________________________________

6. FAMILY MEMBERS WITH ALLERGIC SYMPTOMS
   - [ ] Mother  [ ] Father  [ ] Brother/Sister  [ ] Grandparents  [ ] Son/Daughter  [ ] Spouse  [ ] None

7. Please answer all: Do you carry an Epi pen? Yes / No
   - Were you ever advised to carry an Epi pen? Yes / No
   - Were you ever told that you had an ‘anaphylactic reaction? Yes / No
   - Have you ever had an anaphylactic reaction? Yes / No
   - Has your throat ever closed or nearly closed due to an allergic reaction? Yes / No

8. If you are susceptible to an anaphylactic reaction, what will bring it on? i.e. shell fish, peanuts, etc…: ____________

9. Do you have a current medical condition, i.e. MS, epilepsy, diabetes, lupus? No / Yes

10. Are you pregnant? No / Yes
11. WHEN do the symptoms occur (circle all that apply): Daily, when I wake up, morning, afternoon, or night

12. WHEN ARE YOUR SYMPTOMS WORSE: □ Year around

13. WHERE DO THE SYMPTOMS EXPRESS THEMSELVES THE MOST?
    Outdoors: Near home, near work, near school, friends house, relatives house, other:
    Indoors: home, work, school, friends house, relatives house, other:
    □ Outdoors and better indoors
    □ In the bedroom or when in bed
    □ During wet or damp weather
    □ During known pollen seasons
    □ When exposed to tobacco smoke
    □ When sweeping or dusting the house
    □ In air conditioning
    □ Tobacco smoke bothers me more than anything else
    □ During windy weather
    □ When the weather changes
    □ In certain rooms or buildings
    □ With yard work, cut grass, leaves, hay or barns
    □ In areas with mold or mildew
    □ In fields or in the country

14. How long does it take you to notice the symptoms: within minutes, hours, 2-3 days? _______________________

15. SYMPTOMS ARE BETTER
    What makes you feel better? ____________________________
    □ After shower or bath □ Indoors □ outdoors □ After taking antihistamines or medication □ With allergy shots

16. ANIMALS, INSECTS AND BIRDS THAT CAUSE SYMPTOMS ON EXPOSURE
    □ None □ Dogs □ Cats □ Rodents (mice, guinea pigs, etc.) □ Horses or Cattle □ Rabbits □ Birds or Feathers
    □ Bees □ Other ____________________________

17. FOOD RELATED SYMPTOMS □ No problem with foods
    □ Some foods are craved or addictive
    □ The smell or odor of some foods increases symptoms
    □ Some foods cause swelling of the mouth or tongue
    □ Some foods cause upset stomach or vomiting
    □ Symptoms occur with restaurant salad bars or Asian foods
    □ Symptoms occur with any regularly eaten food
    □ Preservatives, additives or food coloring increase symptoms
    □ Some foods cause nasal symptoms
    □ Some foods cause rashes or hives
    □ Some foods cause diarrhea
    □ Some foods cause headaches
    □ Some foods cause asthma

18. Why do you believe your symptoms are related to food? ____________________________________________?

19. Do you notice symptoms when you or someone else cleans, sweeps, dusts, or vacuums? _____________________

20. CHEMICALS THAT CAUSE YOUR SYMPTOMS □ None
    □ Insecticides & pesticides
    □ Gasoline or automobiles exhaust
    □ The smell of new fabrics or fabric store
    □ Laundry detergent
    □ Paints & household cleaners
    □ Stove or furnace emissions
    □ Chemicals in the workplace
    □ Other: ____________________________

21. Do you notice the symptoms when you are around wet or damp places? _________________________________
22. PREVIOUS ALLERGY EVALUATION
Have you ever seen an allergist? □ Yes □ No  Have you ever received allergy injections? □ Yes □ No
Have you had allergy skin testing? Yes / No  Have you had allergy Blood testing? Yes / No
If yes, please list positive allergens (include any medications)

23. WERE YOU PREVIOUSLY DIAGNOSED WITH ALLERGIES? □ NO
□ Yes and allergy shots helped □ Yes but allergy shots did not help
□ Yes and medication helped □ Yes but medication did not help

24. MEDICATIONS: Do you take any of the following medications on a regular basis?
□ Antihistamines (Benadryl, Actifed, Chlortrimeton, Tylenol Sinus, Tylenol Sleep, Dimetapp, Drixoral, Trimalin, Atarax, Claritin, Allegra, Zyrtec, etc)
□ Bronchodilators (Albuterol, Ventolin, Proventil, Serevent, or OTS’s such as Primatine Mist, etc)
□ Steroid Inhalers (Asmacort, Flovent, Pulmicort, Beclomethasone, Aerobid, Advair, etc)
□ Nasal Steroids (Beconase, Flonase, Nasacort, Rhinocort, etc)
□ Medications that affect the immune system (Prednisone, Imuran, Methotrexate, Cellcept, Cyclosporine, Tacrolimus, etc)
□ Chemotherapy
Please list any medications not listed above that you are currently taking:

25. DO YOU SMOKE? □ NO
If yes, average number of cigarettes per day _______ If yes, at what age did you start? ______________________
Are you around smoke in your home or work environment? □ Yes □ No

26. WORK ENVIRONMENT
What is your occupation? ______________________________
Are you exposed to chemicals or strong odors at work? □ Yes □ No  If yes, briefly explain________________________
Are your symptoms worse while at work? □ Yes □ No  If yes, briefly explain________________________

27. Hobby
Do you have a hobby or hobbies? If so, what are they? ______________________________
Does someone you live with have hobbies? Yes / no  If yes, what are they? ______________________________

Doctor's Note's:

Revised Jan 2011
check only the **symptom(s)** and known **allergen(s) and symptom triggers** that brought you to our office today:

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Allergen</th>
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<tbody>
<tr>
<td>Irritable Bowel (IBS)</td>
<td>Eggs</td>
</tr>
<tr>
<td>Bloating</td>
<td>Milk / dairy / cheese</td>
</tr>
<tr>
<td>Constipation / diarrhea</td>
<td>Corn</td>
</tr>
<tr>
<td>Stomach / intestinal pains or cramps</td>
<td>Sugar</td>
</tr>
<tr>
<td>Heart burn</td>
<td>Wheat / grains / bread</td>
</tr>
<tr>
<td>Reddening of ears</td>
<td>Soy</td>
</tr>
<tr>
<td>Ringing in ears</td>
<td>Fruit</td>
</tr>
<tr>
<td>Ear aches / ear infections</td>
<td>Vegetables</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>Chocolate</td>
</tr>
<tr>
<td>Stuffy nose / runny nose</td>
<td>Coffee / tea</td>
</tr>
<tr>
<td>Hay fever</td>
<td>Meat / beef / chicken / pork</td>
</tr>
<tr>
<td>Sneezing attacks</td>
<td>Fish: shellfish / other fish</td>
</tr>
<tr>
<td>Excessive mucus / clearing throat</td>
<td>Peanut</td>
</tr>
<tr>
<td>Asthma</td>
<td>Tomato</td>
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<tr>
<td>Chronic cough</td>
<td>Yeast</td>
</tr>
<tr>
<td>Sore throats</td>
<td>Wine</td>
</tr>
<tr>
<td>Hoarse voice / loss voice</td>
<td>Artificial: coloring / preservatives / flavors</td>
</tr>
<tr>
<td>Tingling lips</td>
<td>Acne</td>
</tr>
<tr>
<td>Sinusitis</td>
<td>Chemical sensitivities</td>
</tr>
<tr>
<td>Hay fever</td>
<td>Dust / dust mites</td>
</tr>
<tr>
<td>Excessive mucus / clearing throat</td>
<td>Hives / rash / dry skin</td>
</tr>
<tr>
<td>Asthma</td>
<td>Chemical sensitivities</td>
</tr>
<tr>
<td>Chronic cough</td>
<td>Cleaning products</td>
</tr>
<tr>
<td>Sore throats</td>
<td>Personal care products: deodorant / make up,</td>
</tr>
<tr>
<td>Hoarse voice / loss voice</td>
<td>Perfume: the kind you put on your skin</td>
</tr>
<tr>
<td>Tingling lips</td>
<td>Scented candles / odors / smells</td>
</tr>
<tr>
<td>Acne</td>
<td>Toilet paper</td>
</tr>
<tr>
<td>Eczema / Psoriasis</td>
<td>Watery itchy eyes</td>
</tr>
</tbody>
</table>
| Itching skin                                 | Things you touch: metal / paper / ink / latex /
| Hives / rash / dry skin                     | fabric                                        |
| Hot flashes                                  | Red / swollen / itchy / eyelids               |
| PMS / painful menstruation                   | Dark circles under eyes                       |
| Chronic yeast infections                     | Animals: cat / dog / other                    |
| Headache                                     | Sun                                           |
| Dizziness                                    | Medication                                    |
| Irregular heart beat                         | Other allergens:                              |
| Other conditions and symptoms                | MS                                            |
| Mood swings                                  | Lupus                                         |
| Depression                                   | Autism                                        |
| Anger / fear / nervousness                   | Autoimmune disorder                           |
| Fatigue                                      | ADD / ADHD                                    |
| Other symptoms:                              | Obsessive compulsive disorder (OCD)          |
| Allergens                                    |                                               |