### SYMPTOMS

Describe your symptoms (check all that apply):

- __ Shortness of breath__
- __ Chest Pain__
- __ Nasal Congestion__
- __ Eye Redness__
- __ Skin Itching__
- __ Wheezing__
- __ Hoarseness__
- __ Nasal Discharge__
- __ Eye Itching__
- __ Skin Dryness__
- __ Chest Tightness__
- __ Throat Irritation__
- __ Post Nasal Discharge__
- __ Eye Swelling__
- __ Skin Rash__
- __ Exercise Limitation__
- __ Chronic Cough__
- __ Frequent Sneezing__
- __ Heartburn/Reflux__
- __ Limitation at Rest__
- __ Frequent Headaches__
- __ Post Nasal Discharge__
- __ Frequent Headaches__
- __ Limitation at Rest__
- __ Exercise Limitation__
- __ Stress__

**Symptoms**

(Include in order of severity)

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<tr>
<th>Symptoms</th>
<th>Onset Date</th>
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**Factors which aggravate symptoms (check all that apply):**

- __ Seasonal (as above)__
- __ Cold Air__
- __ Odors/Perfume__
- __ Nocturnal/Sleep__
- __ Medications__
- __ Exercise__
- __ Heat Humidity__
- __ Smoke__
- __ Heartburn/Reflux__
- __ Aspirin__
- __ Infections__
- __ Animals__
- __ Stress__
- __ Foods__
- __ Other ________

### ALLERGIC HISTORY

Have you been evaluated and/or treated for this or other allergic/respiratory conditions in the past?

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<td>1.</td>
<td>Yourself</td>
<td>Date</td>
<td>Over The Counter Medications (OTC)</td>
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<td>Primary Care M.D.</td>
<td>Date</td>
<td>Treatment</td>
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<td>3.</td>
<td>Allergists/Other Specialists</td>
<td>Date</td>
<td>Allergy Tests/labs/x-rays</td>
<td>Treatment</td>
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<td>What prompted you to seek an allergy evaluation at this time?</td>
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<td>5.</td>
<td>Who suggested that you seek evaluation at this time (self, family, friend, M.D.)?</td>
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<td>How did you hear about us?</td>
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### General Medical History:

**OTHER MEDICAL HISTORY (including all non-allergy diagnosis)**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Since</th>
<th>Treatment</th>
<th>Active</th>
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**IMMUNIZATIONS**

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<th>Vaccine</th>
<th>Date</th>
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**PRIOR SURGERY / HOSPITAL / EMERGENCY ROOM VISITS**

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Date</th>
<th>Hospital</th>
<th>Treatment</th>
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**ALLERGIES**

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<tr>
<th>Symptoms</th>
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**PREVIOUS ALLERGY / ASTHMA MEDICATIONS (Prescription and OTC)**

<table>
<thead>
<tr>
<th>Medicines (Inhalers, Pills, Oral Steroids)</th>
<th>Dose (Sprays, mg)</th>
<th>Times Per Day</th>
<th>Start Date</th>
<th>Stop Date</th>
<th>Effective?</th>
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**CURRENT MEDICATIONS (List all medications you are presently taking)**

<table>
<thead>
<tr>
<th>Medicines (Inhalers, Pills, Oral Steroids)</th>
<th>Dose (Sprays, mg)</th>
<th>Times Per Day</th>
<th>Start Date</th>
<th>Prescribed By</th>
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### Environmental Survey

**RESIDENCE**

- City
- House/Apt.
- Age of Structure

**SMOKING**

- Cigarettes ___ packs per day
- # years smoking ___
- Start/Stop date ___
- Other
- Smokers at home ___

**ALCOHOL USE** (drinks per day)

- Beer ___
- Wine ___
- Spirits ___
- Other ___

**EMPLOYMENT**

- Occupation
- Work Environment
  - Dust/Smoke
  - Chemicals
  - Other Irritants

**Family Medical History**

- List all allergic and non-allergic medical conditions:
  - Mother
  - Father
  - Siblings
  - Children
  - Other relatives

Please bring all of your medications, copies of any prior allergy evaluations, relevant diagnostic tests and this form to your evaluation. If you have any questions, please call us at (617) 232-1690.

---

**Patient/Guardian Signature**

**Date**

**Daniel G. Steinberg, M.D.**

**Date**

**John L. Ohman, M.D.**

**Allergy/Clinical Immunology**