East Texas Allergy & Asthma Associates
1009 N. 4th St, Suite A -- Longview, TX 75601
Phone: (903)757-3808 Fax: (903) 757-3893
www.etxallergy.com

Patient Name:_____

Date of Birth:_____ Date form completed_____

Reason for visit:_____

How did you hear about us? Doctor Referral (Who?_____) Friend/Family Internet

Nasal Symptoms	**Rarely or Not at all**	**Less than 2 times / week**	**Greater than 2 times / week**	**Every day**
Drainage (runny nose)				
Congestion				
Postnasal drainage				
Loss of smell				
Sinus pressure				
Throat clearing				
Sore throat				
Snoring				
Earache				
Eye itching				
Eye redness				
Eye burning				
Eye tearing				
Hoarseness				
Sneezing				
Headaches				

Breathing Symptoms	**Rarely or Not at all**	**Less than 2 times / week**	**Greater than 2 times / week**	**Every day**
Shortness of breath				
Chest tightness				
Wheezing				
Pain with breathing				
Sputum / phlegm				
Nighttime cough / wheeze				
Nighttime awakening with cough or shortness of breath				

Aggravating Factors	**Nasal**	**Eye**	**Chest**	**Skin**
Animals: cat, dog, bird, horse				
Pollens: grass, trees, weeds				
Irritants: smoke, perfume, dust, odors				
Temperature change				
Emotions: laugh, cry or stress				
Exercise				

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Have you ever missed work or school due to allergies, asthma or sinus disease? YES NO
Have you ever gone to the Emergency Department with an allergy problem? YES NO
Have you ever been hospitalized for an allergy or asthma problems? YES NO
If yes, when? _____
Have you ever had nose, ear or sinus surgery, including tube placement? YES NO
If yes, when? _____
Have you ever been prescribed antibiotics (YES / NO) or steroids (YES / NO) for the above?
Have you ever received immunotherapy (allergy shots) YES NO

Please list other allergy medications tried and how long used:
Nasal sprays_____
Pills_____ _____ ___Eye drops_____
Inhalers_____

Past Medical History
Please list any current medical problems _____
_____
_____

Please list and date any previous surgeries _____
_____
_____

Please list any hospitalizations _____
_____

Are immunizations up to date? YES NO

Family History	Mother	Father	Siblings	Children	Other relatives
Hay fever					
Asthma					
Eczema					
Food allergy					
Diabetes					
Heart disease					
Cancer					
Psychiatric condition					

Other _____
_____
_____
_____

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Please list **ALL** medications you are currently taking, including any "over the counter" medications.

Include all inhalers, medicated creams and nasal sprays. If you take more medications than can be listed in the box below, please bring a prepared list to assist with the check-in process.

Medication Name	Strength (mg or grams)	Dose (daily, 2x/day, weekly, etc)

Please list any drug allergies and the associated reaction

Medication Name Reaction (be specific) When did this happen?

Environmental checklist: Please check all that apply to your home

- o Water leaks
- o Dust mite proof encasings on pillows, mattress and box springs
- o Animals are in the house If so, what kind_____
- o Animals are in the bedroom
- o Cigarettes are smokes inside or outside the home
- o Carpeting in the bedroom
- o Central air and heating
- o Vent filters in the bedroom
- o HEPA filter in the bedroom
- o Dehumidifier in the home
- o Windows closed in pollen season
- o Bedding washed weekly