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Patient name: _____

Laboratory Tests (dates and results):

X-rays: (where they were taken) (when) (results)

Chest _____

Sinus _____

Other _____

Previous Allergy Tests (allergic to):

_____

_____

Doctor:_____ Date Tested: _____

Allergy shots given? No Yes, from _____ to_____

Environment:

Basement? [ ] yes [ ] no is it: [ ] dry [ ] damp [ ] musty smelling [ ] carpeted

Carpet in bedroom? [ ] no [ ] yes it is: [ ] wall to wall [ ] wool [ ] cotton [ ] synthetic

The pad is: [ ] rubber/foam [ ] hair ozite

How old is the carpet? _____

Heat type: [ ] gas [ ] electric [ ] coal [ ] oil [ ]wood [ ] fireplace other: _____

[ ] Radiators [ ] hot air blower [ ] gravity [ ] radiant baseboard

Smoking Habits:

Does patient smoke: [ ] no [ ] yes, if yes, how many packs a day: _____/day, for_____years

Smokers in household: [ ] Father [ ] Mother [ ] Wife [ ] Husband [ ] others

Smokers at work/school: [ ] yes [ ] no

Bedroom:

Pillow: **[ ]** feather [ ] foam [ ] synthetic [ ] other:_____

Mattress: [ ] coil mattress [ ] foam rubber [ ] water bed [ ] other:_____

Mattress covered: [ ] no [ ] yes, if yes, is the cover: [ ] plastic [ ] cotton

Blankets: [ ] cotton [ ] wool [ ] feather/down [ ] synthetic [ ] other:_____

Pets:

Outdoors: [ ] dog [ ] cat [ ] horse [ ] other: _____

Indoors: [ ] dog [ ] cat [ ] bird [ ] fish [ ] other: _____

Other comments:

_____

_____

_____

_____

_____

_____