Date:______________

# INITIAL ALLERGY EVALUATION

Patient Name: ____________________________________________

Patient Number: ________________ Date of Birth: ________________

Physician: ________________ Patient Phone: ________________

Patient Insurance Information: ________________________________

## PATIENT HISTORY

| | YES | NO |
|---|---|---|
| Do you have symptoms or have you ever had symptoms such as sneezing, watery nasal discharge, or nose and throat itching? | ______ | ______ |
| Do you have, or have you ever had, frequent "colds", sinus problems or chronic nasal congestion? | ______ | ______ |
| Do you have or have you ever had your eyes itch, water, get red or swell? | ______ | ______ |
| Are your symptoms seasonal only? | ______ | ______ |
| Do your symptoms change or have they ever changed when you go indoors or outdoors? | ______ | ______ |
| Are your symptoms worse around animals? | ______ | ______ |
| Do you have any blood relatives with allergies? | ______ | ______ |
| Do you have, or have you ever had, asthma, rash or hives? | ______ | ______ |
| Do you experience dry eyes or dry mouth? | ______ | ______ |
| Does food effect your symptoms? If yes, what FOODS? | ______ | ______ |

____________________________________________

**Yes for one or more questions indicates potential allergies, and patient may be a candidate for a simple allergy test.**