

FOODS: (List) _____

OTHER: Trees Grasses Weeds Air Conditioning
 Exertion Fatigue Excitement Tension (anxiety)
 Laughing Chilling Infection Menses (periods)
 Dampness Aspirin Wind

Symptoms began: _____

Are symptoms year round or seasonal? _____

What month(s) do symptoms usually occur? _____

What time of the day or night are symptoms worse? _____

Frequency of attacks (circle one): Daily Weekly Monthly

Duration of symptoms: _____

Longest period symptom-free without medication: _____

Progression: Are symptoms better, worse, the same? _____

Is patient prone to frequent infections? Y N Type/Frequency: _____

Does patient experience more than 3-4 "colds" per year? Y N _____

Is nervousness a problem? Y N Describe: _____

Has patient ever had a serious reaction to a bee, wasp or hornet sting? Y N

Describe: _____

How much school or work has been missed in the past year because of allergy or asthma?

FOOD ALLERGY

What now or in the past has caused trouble? _____

Have you tried eliminating foods from your diet? Y N If so, please list:

Food eliminated	Duration	Results

PREVIOUS ALLERGY STUDIES

Have skin tests been done before? Y N Doctor: _____

Date: _____ Results: _____

Duration of injections or treatments: _____