



PATIENT QUESTIONNAIRE

1. This consultation was arranged to evaluate what problem? (List illness or symptom)  
a) \_\_\_\_\_  
b) \_\_\_\_\_
2. When is the first time the problem occurred?  
a) \_\_\_\_\_  
b) \_\_\_\_\_
3. Where did the problem occur the first time?  
a) \_\_\_\_\_  
b) \_\_\_\_\_
4. Describe your first episode. \_\_\_\_\_  
\_\_\_\_\_
5. Describe a typical episode. \_\_\_\_\_  
\_\_\_\_\_
6. When did your last episode occur? DATE: \_\_\_\_\_
7. How often do you have symptoms? Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Yearly \_\_\_\_\_
8. If your problem occurs consistently at certain times of year please indicate the symptom(s) and put an "X" under which month(s) it regularly occurs.

<u>Symptom(s)</u>	<u>Jan</u>	<u>Feb</u>	<u>Mar</u>	<u>Apr</u>	<u>May</u>	<u>Jun</u>	<u>Jul</u>	<u>Aug</u>	<u>Sept</u>	<u>Oct</u>	<u>Nov</u>	<u>Dec</u>
1) _____												
2) _____												
3) _____												

9. Or does it occur almost equally all year long? \_\_\_\_\_ yes \_\_\_\_\_ no
10. If your problem occurs consistently is it consistently in the:  
Morning \_\_\_\_\_ Weekdays only \_\_\_\_\_  
Afternoon \_\_\_\_\_ Weekends only \_\_\_\_\_  
Evening \_\_\_\_\_ Other \_\_\_\_\_

11. SELECT all of your symptoms that occur regularly. If you have no problems in that system SELECT:NONE.
1. Eyes: a) itching b) irritation or burning c) redness d) swollen eye lids e) watery discharge f) dryness g) frequent infections h) light sensitivity I) mucous discharge j) NONE
  2. Ears: a) popping b) tinnitus (ringing) c) discharge (indicate type: blood\_\_ pus\_\_ colored\_\_ what color:\_\_\_\_\_ ) d) frequent infection e) pruritus (itching) f) frequent serous otitis (fluid in ears) g) NONE
  3. Nose: a) stuffiness b) itching c) sneezing d) polyps e) frequent colds f) clear discharge g) colored discharge (indicate type: blood\_\_ pus\_\_ colored\_\_ what color:\_\_\_\_\_ ) h) purulent discharge i) bloody discharge j) one-sided discharge of any type that is consistent k) NONE
  4. Throat, Lips a) itching throat b) swollen lip or tongue c) sore throat d) excess mucous e) post nasal drip f) NONE
  5. Sinus: a) pain over forehead b) pain behind eyes c) pain behind bridge of nose d) recurrent sinus infection e) pain in back of the head f) pain on top of head in front g) pain over temples h) NONE
  6. Chest: a) wheezing b) cough c) shortness of breath d) tightness in chest e) pain in chest f) spitting up clear mucous g) coughing up mucus plugs (spaghetti shaped mucus) h)spitting up colored mucous (indicate type: Blood\_\_ pus\_\_ colored\_\_ what color:\_\_\_\_\_ ) i) blood tinged j) blood streaked k) bloody discharge l) purulent discharge m) ever had pneumonia? When\_\_\_\_\_ n) ever had bronchitis? When\_\_\_\_\_ o) ever had asthma? When diagnosed?\_\_\_\_\_ p) NONE
  7. Skin: a) itching b) eczema c) hives d) rash e) blisters f) NONE
  8. Bowels: a) nausea b) upset c) diarrhea d) bloating e) cramps f) colic g) NONE
12. Is your illness increasing in frequency or severity?  
a) Frequency: \_\_\_\_ yes \_\_\_\_ no b) Severity: \_\_\_\_ yes \_\_\_\_ no
13. Does your illness cause you to:  
a) Be ill in the morning when you wake up? \_\_\_\_ yes \_\_\_\_ no  
b) Wake up ill during the night? \_\_\_\_ yes \_\_\_\_ no
14. Do you suffer from:  
a) Difficulty in going to sleep? \_\_\_\_ yes \_\_\_\_ no  
b) Difficulty in waking up? \_\_\_\_ yes \_\_\_\_ no  
c) Unusual sleepiness during the waking hours? \_\_\_\_ yes \_\_\_\_ no
15. If you are a woman:  
a) Are you pregnant? \_\_\_\_ yes \_\_\_\_ no If yes, at which month of pregnancy? \_\_\_\_  
b) Are you planning to become pregnant in the near future? \_\_\_\_ When \_\_\_\_  
c) Are you nursing a baby at this time? \_\_\_\_ yes \_\_\_\_ no  
d) Your menarche started when? \_\_\_\_  
e) Your menopause started when? \_\_\_\_

16. Have you ever seen an Ear Nose & Throat specialist? \_\_\_yes \_\_\_no If yes when \_\_\_\_\_  
Did this ENT perform surgery? \_\_\_yes \_\_\_no. If yes, what surgery \_\_\_\_\_  
Did the surgery help your problem? \_\_\_yes \_\_\_no \_\_\_somewhat \_\_\_not sure

17. Have you ever seen an Allergist for this problem previously? \_\_\_ yes \_\_\_ no  
If yes: a) What year was the initial visit? \_\_\_\_\_ Dr.'s Name: \_\_\_\_\_  
b) Over what period of time did you see him/her \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ to \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_  
Mo / yr. Mo / yr.

c) What did he/she find you allergic to? (put an "X" next to those that apply)

- |               |                          |                 |
|---------------|--------------------------|-----------------|
| Ragweed _____ | Dog _____                | Cockroach _____ |
| Grass _____   | Cat _____                | Latex _____     |
| Trees _____   | Weeds _____              |                 |
| Dust _____    | Foods _____(List: _____) |                 |
| Mold _____    | Drugs _____(List: _____) |                 |
| Mite _____    | OTHER _____(List: _____) |                 |

d) Did he/she treat you with immunotherapy (allergy shots): \_\_\_yes \_\_\_no

If yes: When: from (yr.) \_\_\_\_\_ to (yr.)\_\_\_\_\_

What were you treated for? \_\_\_\_\_

e) Did the treatment help you? \_\_\_yes \_\_\_no \_\_\_somewhat \_\_\_not sure

f) Why were the allergy shots stopped? \_\_\_\_\_

18. What medication(s) do you **currently take for your allergic** problem?(For inhalers: list # puffs)

(Example: Proventil inhaler: Dose: 2 puffs Frequency:4 times/day)

- 1) \_\_\_\_\_ Dose (or # puffs): \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 2) \_\_\_\_\_ Dose (or # puffs): \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 3) \_\_\_\_\_ Dose (or # puffs): \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 4) \_\_\_\_\_ Dose (or # puffs): \_\_\_\_\_ Frequency: \_\_\_\_\_/day.

19. What medication(s) have you **taken previously for your allergic** problem?

- 1) \_\_\_\_\_ Dose (or # puffs): \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 2) \_\_\_\_\_ Dose (or # puffs): \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 3) \_\_\_\_\_ Dose (or # puffs): \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 4) \_\_\_\_\_ Dose (or # puffs): \_\_\_\_\_ Frequency: \_\_\_\_\_/day.

20. What medication(s) do you **currently take for any other reason**? List **all** including non-prescription.

- 1) \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 2) \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 3) \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_/day.
- 4) \_\_\_\_\_ Dose: \_\_\_\_\_ Frequency: \_\_\_\_\_/day.

21. Were you ever in a hospital? \_\_\_ yes \_\_\_ no If yes:

- a) When? \_\_\_\_\_
- b) At which hospital \_\_\_\_\_
- c) Why were you hospitalized? \_\_\_\_\_
- d) If asthmatic: How many times have you been to an emergency room for asthma: \_\_\_\_\_
- e) If asthmatic: How many times have you been hospitalized for asthma \_\_\_\_\_
- f) If asthmatic: Have you ever been put on a respirator or into an intensive care unit \_\_\_yes \_\_\_no

22. Insect Hypersensitivity: (select any symptoms you have had after a bite or sting)

- a) Stinging Insects:                      a) swelling b) hives c) shortness of breath d) anaphylaxis e) shock
- b) Non-stinging Insects:              Unusual reaction to \_\_\_ flies \_\_\_ mosquitoes.

23. Are you in good health? \_\_\_ yes \_\_\_ no

24. Do you currently have or did you ever have any of the following:

- \_\_\_ Frequent headaches                      Describe: \_\_\_\_\_
- \_\_\_ Glaucoma or Family History of Glaucoma
- \_\_\_ Dental Problem                              Describe: \_\_\_\_\_
- \_\_\_ Frequent Swollen Glands
- \_\_\_ Hypertension (high blood pressure)
- \_\_\_ Heart Disease
- \_\_\_ Anemia or other blood disease
- \_\_\_ Liver or Kidney Disease
- \_\_\_ Thyroid or Endocrine Disease
- \_\_\_ Tuberculosis
- \_\_\_ Prostate problem
- \_\_\_ Diabetes
- \_\_\_ Risk for HIV infection or AIDS                      Describe: \_\_\_\_\_
- \_\_\_ Psychiatric or nervous disorder Describe: \_\_\_\_\_
- \_\_\_ Addictions or addictive behaviors                      Describe: \_\_\_\_\_
- \_\_\_ Other \_\_\_\_\_

25. Does any food make you ill or produce allergic symptoms?

<u>Food</u>	<u>Symptom(s)</u>
a) _____	_____
b) _____	_____
c) _____	_____

26. Did any food make you ill or produce allergic symptoms which you have outgrown?

<u>Food</u>	<u>Symptom(s)</u>
a) _____	_____
b) _____	_____
c) _____	_____

27. Does any medication(s) make you ill or produce allergic symptoms?

<u>Medication</u>	<u>Symptom(s)</u>
a) _____	_____
b) _____	_____
c) _____	_____

28. Are you or have you ever undergone alternative medical treatments? \_\_\_yes \_\_\_no If yes, describe:

- a) What type: \_\_\_\_\_
- b) When: \_\_\_\_\_
- c) Where: \_\_\_\_\_
- d) Outcome: \_\_\_\_\_

29. Do symptoms occur around (check all that apply):

<input type="checkbox"/> old leaves	<input type="checkbox"/> hay	<input type="checkbox"/> animals
<input type="checkbox"/> lakeside	<input type="checkbox"/> barns	<input type="checkbox"/> rubber (latex) products
<input type="checkbox"/> summer homes	<input type="checkbox"/> damp basement	<input type="checkbox"/> Other _____
<input type="checkbox"/> dry attic	<input type="checkbox"/> lawn mowing	

30. Are your symptoms produced by or aggravated by (check all that apply):

<input type="checkbox"/> alcohol	<input type="checkbox"/> heat	<input type="checkbox"/> cold
<input type="checkbox"/> perfumes	<input type="checkbox"/> paints	<input type="checkbox"/> cosmetics
<input type="checkbox"/> insecticides	<input type="checkbox"/> air conditioning	<input type="checkbox"/> muggy weather
<input type="checkbox"/> weather changes	<input type="checkbox"/> temperature changes	<input type="checkbox"/> chemicals
<input type="checkbox"/> hair spray	<input type="checkbox"/> newspapers	<input type="checkbox"/> house dust
<input type="checkbox"/> hot foods	<input type="checkbox"/> cold foods	<input type="checkbox"/> laughing
<input type="checkbox"/> crying	<input type="checkbox"/> emotions	<input type="checkbox"/> strong odors
<input type="checkbox"/> cold front	<input type="checkbox"/> air pollution	<input type="checkbox"/> bus fumes
<input type="checkbox"/> auto fumes	<input type="checkbox"/> OTHER _____	

31. Do you have pets?  yes  no If yes:

Type of pet	How many?	Year acquired?	Year removed?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

32. Does being near any animal make you worse  yes  no If yes, which one(s)?

a) \_\_\_\_\_ Indicate Symptom(s): \_\_\_\_\_

b) \_\_\_\_\_ Indicate Symptom(s): \_\_\_\_\_

33. Has your current house ever been exterminated for cockroaches?  yes  no  
 Have you ever seen a cockroach in your house?  yes  no  not since extermination.

34. Have you **ever** smoked:  yes  no If yes, what?

cigarettes  pipe  other: \_\_\_\_\_

a) How many per day? \_\_\_\_\_

b) When did you start? \_\_\_\_\_ (approximate year)

c) When did you stop? \_\_\_\_\_ (approximate year)

d) Have you ever tried to stop  yes  no How:  patch  gum  nasal spray  cold turkey  hypnosis  pill  other (describe): \_\_\_\_\_

e) Is there a smoker in your house?  yes  no  sometimes

35. Have you lived for more than one year away from the northeast?  yes  no If yes:

a) Where? \_\_\_\_\_

b) For how long? \_\_\_\_\_

c) Did you have your problem while in that area?  yes  no  yes, but less severe

36. If you have traveled while you have had your current problem, please list where you traveled, how long, and whether you were better, worse or no change.

a) \_\_\_\_\_ How long? \_\_\_\_\_ Better \_\_\_\_\_ Worse \_\_\_\_\_ No Change \_\_\_\_\_

b) \_\_\_\_\_ How long? \_\_\_\_\_ Better \_\_\_\_\_ Worse \_\_\_\_\_ No Change \_\_\_\_\_

c) \_\_\_\_\_ How long? \_\_\_\_\_ Better \_\_\_\_\_ Worse \_\_\_\_\_ No Change \_\_\_\_\_

37. If the patient is a child less than 17 yr. old answer the following. (If age 17 or above skip this question)
- a) Normal growth and development: \_\_\_yes \_\_\_no (If no, explain: \_\_\_\_\_)
  - b) Was this child breast fed: \_\_\_ yes \_\_\_ no (If yes, until what age: \_\_\_\_\_)
  - c) Vaccines up to date: \_\_\_yes \_\_\_no (Describe any unusual reactions to vaccines:\_\_\_\_\_)
  - d) Behavior problems: \_\_\_yes \_\_\_no (Describe: \_\_\_\_\_)
  - e) Describe any unusual childhood illnesses:\_\_\_\_\_)
  - g) Frequent infections? \_\_\_ yes \_\_\_no (If yes, describe: \_\_\_\_\_)
  - h) Performance in school: \_\_\_Above average \_\_\_average \_\_\_below average
  - i) Check number of school days missed in past year because of illness: 0-3 4-7 8-11 12 or more
  - j) Does the child live with both biological parents? \_\_\_yes \_\_\_no If no,describe : \_\_\_\_\_
- 

38. Select others living with patient: 1) Spouse 2) Significant other 3) Children: number: \_\_\_ 4) Mother  
5) Father 6) Relative 7) Friend 8) I live alone

The following questions are to gain understanding of your personal history. (If patient is a child, questions apply to the parent completing this form)

Describe sources of stress in your life: 1) Relationship: \_\_\_\_\_

2) Job: \_\_\_\_\_ 3) Your Health: \_\_\_\_\_

4) Money: \_\_\_\_\_ 5) Conflicts: \_\_\_\_\_

5) Health of others: \_\_\_\_\_

Are you happy with your life the way it currently is \_\_\_yes \_\_\_no \_\_\_ somewhat

What changes would you like to make in your life to improve it ? \_\_\_\_\_

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39. **Occupational History:** (to gain understanding of possible allergenic or chemical exposures)

List jobs held for past 15 years by job type (e.g. Sales clerk, nurse, teacher): \_\_\_\_\_

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Have you ever worked in a health care related job: \_\_\_yes \_\_\_no If yes: did you wear latex gloves frequently? Did you or do you sneeze or itch or rash when you put on latex gloves? \_\_\_yes \_\_\_no

Check any of the following if they are relevant to a current or previous job: beautician, chemicals, cosmetics, dyes, embalming, epoxy or glue, fabric manufacture, fiber glass, insulation, laboratory work, laminating, latex, meat wrapping, metal working, painting, plastics, polyurethane, rubber, textile work, wood working.

40. **Diet history.** Check all that you eat daily or almost daily : fruits, vegetables, milk, cheese, breads, cereal, poultry, red meat, fish, shellfish, candies, chocolate, pastries, juices, beer, wine, liquor.
41. Have you had sneezing, nasal congestion or wheezing when eating (check any that apply) 1) at salad bars 2) dried fruits 3) wine 5) beer 4) sauces or gravies 5) pickles 6) shrimp 7) cider 8) vinegar
42. Have you ever gotten hives (check any that apply): 1) when exercising 2) when showering 3) when exposed to cold air 3) when exposed to sun 4) on the bottom of your feet 5) under a tight belt.

ENVIRONMENTAL EVALUATION

**IF YOU HAVE MORE THAN ONE HOME, GET A SEPARATE ENVIRONMENTAL EVALUATION FOR EACH**

1. Do you work in  a. office  b. factory  c. school  d. house  e. other \_\_\_\_\_

If a factory, what type? \_\_\_\_\_

Is your work place:  dusty  smoky

a) Is your house in a wooded area?  yes  no

b) Is there a garden around the house?  yes  no

c) Are you predominantly in an area with: (CHECK ALL ITEMS THAT APPLY)

trees  grass  weeds

urban buildings mainly  polluted area

2. Do you live in a(n)  a. apartment  b. house

How old is the dwelling? (circle one)  
1yr 5yr 10yr 20yr or older

Type of neighborhood:  a. city  b. suburb  c. country

3. Is the dwelling  a. dry  b. damp  c. moldy

Do your symptoms become worse after entering a particular room that may be dusty, moldy or cluttered?  no  yes: which room: \_\_\_\_\_

4. If you have a basement is it:  a. finished  b. unfinished  c. damp  d. dry

5. Do you have an air conditioner?  yes  no.

6. If yes, is the air conditioner (select one): central or window

7. If central, does it have a(n)  a. humidifier on the system  b. electronic air cleaner on the system.

c) Does air conditioning make your condition  worse  better  no change

d) When air conditioning is on in your home are you  worse  better  no change

8. Do you have a humidifier in the house?  yes  no Where? \_\_\_\_\_

9. Do you have electronic air cleaners in the house?  yes  no

10. Is there carpeting in your house?  yes  no If yes, is it made of any of the following fabrics: wool, synthetic, shag, low pile or other (PLEASE INDICATE)

<u>Room</u>	<u>Carpet Fabric</u>
a) _____	_____
b) _____	_____
c) _____	_____
d) _____	_____

**ENVIRONMENTAL EVALUATION -2-**

11. What is the carpet padding made of? (felt, foam, synthetic, other-indicate other).

Room

Padding Fabric

- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_
- d) \_\_\_\_\_

12. What are your curtains made of? (synthetic, wool, cotton, fiberglass, blend, other). Are they washable? Are they thick or thin?

Room

Curtain Fabric

Washable?

Thick or Thin?

- a) \_\_\_\_\_
- b) \_\_\_\_\_
- c) \_\_\_\_\_
- d) \_\_\_\_\_

13. Do you have plants in the house? \_\_\_ yes \_\_\_ no If yes,

a) How many? \_\_\_\_\_

b) Are they moldy? \_\_\_ yes \_\_\_ no If yes, which rooms are they situated in? \_\_\_\_\_

14. What type of heating system do you have? \_\_\_\_\_

15. When you leave your house do your symptoms: \_\_\_ increase \_\_\_ decrease \_\_\_ do not change

**BEDROOM**

16. Is there air conditioning in the bedroom? \_\_\_ yes \_\_\_ no If yes, (circle one) central or window

17. If central, does the air conditioning have:

a) a humidifier system? \_\_\_ yes \_\_\_ no

b) an electronic air cleaning system? \_\_\_ yes \_\_\_ no

18. What type of bedding do you use? a) pillows: \_\_\_down \_\_\_foam \_\_\_ Dacron \_\_\_other: \_\_\_\_\_

Do the pillows have a special allergy proof cover? \_\_\_ yes \_\_\_ no

b) Blankets: \_\_\_down \_\_\_synthetic \_\_\_wool \_\_\_other: \_\_\_\_\_

c) Comforters: \_\_\_down \_\_\_synthetic \_\_\_other: \_\_\_\_\_

19. What is your mattress made of? \_\_\_horsehair \_\_\_synthetic \_\_\_ latex \_\_\_ cotton \_\_\_ other: \_\_\_\_\_

Does it have a special allergy proof cover? \_\_\_yes \_\_\_no

20. What is your box spring made of? \_\_\_horsehair \_\_\_synthetic \_\_\_latex \_\_\_cotton \_\_\_other: \_\_\_\_\_

Does it have a special allergy proof cover? \_\_\_yes \_\_\_no

21. Are there plants in the bedroom? \_\_\_yes \_\_\_not If yes, a) How many? \_\_\_\_\_

b) Are they moldy? \_\_\_yes \_\_\_no Where located? \_\_\_\_\_

22. Is there carpeting in your bedroom? \_\_\_yes \_\_\_no

If yes, is the carpet made of: \_\_\_wool \_\_\_synthetic \_\_\_fiber (which fiber): \_\_\_\_\_

\_\_\_shag \_\_\_low-pile \_\_\_flat \_\_\_other: \_\_\_\_\_

**ENVIRONMENTAL EVALUATION -3-**

23. If there is bedroom carpet, what is the padding under the carpet made of:  
\_\_\_ felt \_\_\_ latex \_\_\_ other: \_\_\_\_\_
24. Is the bedroom furniture upholstered? \_\_\_ yes \_\_\_ no If yes, with what? \_\_\_\_\_
25. Are your closets: \_\_\_ full \_\_\_ empty \_\_\_ dusty \_\_\_ camphoric \_\_\_ other: \_\_\_\_\_
26. Are there any leaks in the bedroom? \_\_\_ yes \_\_\_ no
27. Is the bedroom damp? \_\_\_ yes \_\_\_ no
28. Is the bedroom moldy? \_\_\_ yes \_\_\_ no
29. Do you have wallpaper? \_\_\_ yes \_\_\_ no If yes, answer the following:  
a) How old? \_\_\_\_\_  
b) Is there any mold resistant material in the wall paper? \_\_\_ yes \_\_\_ no  
c) Is the wallpaper moldy? \_\_\_ yes \_\_\_ no
30. Are there curtains or drapes? \_\_\_ yes \_\_\_ no (Indicate which) \_\_\_\_\_  
a) Are they: \_\_\_ washable \_\_\_ non-washable  
b) Are they made of: \_\_\_ cotton \_\_\_ wool \_\_\_ synthetic \_\_\_ other: \_\_\_\_\_
31. Are there Venetian blinds on the window(s) \_\_\_ yes \_\_\_ no
32. If you have a bedroom window is it in the close proximity to any potential allergen(s) (e.g., trees or an exhaust vent)? \_\_\_ yes \_\_\_ no If yes, please indicate which allergen(s): \_\_\_\_\_
33. How many air vents open into your bedroom from the heating or the air conditioning? \_\_\_\_\_
34. a) When the heating goes on do your symptoms get: \_\_\_ worse \_\_\_ better \_\_\_ no change  
b) When the air conditioning goes on do your symptoms get: \_\_\_ worse \_\_\_ better \_\_\_ no change
35. Is there any room in the house where you are worse (or where there is no change)? \_\_\_ yes \_\_\_ no  
If yes, please indicate which room(s) \_\_\_\_\_
36. Is there a room in the house where you are better? \_\_\_ yes \_\_\_ no Which room(s) \_\_\_\_\_

**OFFICE OR WORK PLACE**

37. Is there an air conditioner at work? \_\_\_ yes \_\_\_ no If yes, (circle one) central or window
38. If central, does it have: a) a humidifier on the system? \_\_\_ yes \_\_\_ no  
b) an electronic air cleaner on the system? \_\_\_ yes \_\_\_ no  
c) Does the air conditioning at work make your condition: \_\_\_ worse \_\_\_ better \_\_\_ no change  
d) When air conditioning goes on in your home are you: \_\_\_ worse \_\_\_ better \_\_\_ no change
39. Are there air purifiers or humidifiers in your work place? \_\_\_ yes \_\_\_ no  
If yes, indicate which \_\_\_\_\_
40. Is there carpeting in your work place? \_\_\_ yes \_\_\_ no If yes, answer the following:  
a) Is it made of: \_\_\_ wool \_\_\_ synthetic \_\_\_ fiber (indicate type) \_\_\_\_\_  
\_\_\_ shag \_\_\_ low-pile \_\_\_ other: \_\_\_\_\_  
b) What is the padding made of: \_\_\_ felt \_\_\_ foam \_\_\_ synthetic \_\_\_ other: \_\_\_\_\_
41. Do you work in a sealed building (windows are not opened for ventilation)? \_\_\_ yes \_\_\_ no.
42. Does anyone in your workplace have similar symptoms to you? \_\_\_ yes \_\_\_ no.

ENVIRONMENTAL EVALUATION -4-

- 43. Are you exposed to industrial products such as Xerox materials, cleaning chemicals, fumes, etc.?  
 \_\_\_yes \_\_\_no If yes, what type? \_\_\_\_\_
- 44. Are you exposed to various fabrics, dyes, formaldehyde, or industrial toxins?  
 \_\_\_yes \_\_\_no If yes, what type? \_\_\_\_\_
- 45. When the heat is on in your workplace are you: \_\_\_worse \_\_\_better \_\_\_no change
- 46. Are you worse, better, or is there no significant change when you are in your workplace ?  
 \_\_\_worse \_\_\_better \_\_\_no change Are you better on weekends? \_\_\_yes \_\_\_no

<u>PERTINENT PAST HISTORY</u>	<u>DATE</u>	<u>PLACE</u>	<u>RESULTS</u>
LAST CHEST X-RAY	_____	_____	_____
LAST SINUS X-RAY	_____	_____	_____
LAST SINUS CAT SCAN or MRI	_____	_____	_____
LAST PULMONARY FUNCTION TEST	_____	_____	_____
ORAL CORTISONE PRESCRIPTIONS	_____	_____	_____

FAMILY HISTORY OF ALLERGY – “X” appropriate column for each relative who has/had that illness.

	Asthma	Nasal Allergy	Eczema	Hives	Drug Allergy	Food Allergy
<b>Mother</b>						
<b>Father</b>						
<b>Sisters</b>						
<b>Brothers</b>						
<b>Mother’s Sisters</b>						
<b>Mother’s Brothers</b>						
<b>Father’s Sisters</b>						
<b>Father’s Brothers</b>						
<b>Mother’s Parents</b>						
<b>Father’s Parents</b>						
<b>Your Children</b>						

How many children do you have: \_\_\_\_\_ List birth year of each child: \_\_\_\_\_

ANY ADDITIONAL COMMENTS YOU WOULD LIKE TO MAKE ?

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