

FAMILY HISTORY

1. Nasal Polyps	Yes _____	No _____
2. Aspirin Sensitivity	Yes _____	No _____
3. Food Allergy	Yes _____	No _____
4. Drug Allergy	Yes _____	No _____
5. Insect Allergy	Yes _____	No _____
6. Psoriasis	Yes _____	No _____
7. Skin Allergy	Yes _____	No _____
8. Colic	Yes _____	No _____
9. Auto Motion Sickness	Yes _____	No _____
10. Brochitis	Yes _____	No _____
11. Diabetes	Yes _____	No _____
12. Thyroid	Yes _____	No _____
13. Arthritis	Yes _____	No _____
14. Hormonal Problems	Yes _____	No _____
15. Asthma	Yes _____	No _____
16. Hayfever	Yes _____	No _____
17. Eczema	Yes _____	No _____
18. Emphysema	Yes _____	No _____
19. Frequent Infections	Yes _____	No _____
20. Sinus Problems	Yes _____	No _____
21. Tuberculosis	Yes _____	No _____
22. Migraine Headaches	Yes _____	No _____
23. Hives	Yes _____	No _____
24. Cystic Fibrosis	Yes _____	No _____

ENVIRONMENTAL SURVEY:

Time lived in present home _____ Approximately how old is dwelling _____

City _____ Rural _____ Apartment _____ (Older _____ Newer _____)

Do you have pets at home? Yes ____ No ____ Cat ____ Dog ____ Birds ____ Other _____

If you live on afarm, are you exposed to: Chickens ____ Horses ____ Cattle ____ Sheep ____

Hogs ____ Barns ____ Grains ____ Other _____

Bedroom

Pillows: Feather ____ Dacron ____ Foam ____ Encased ____ Other _____

Bed Coverings: Wool blankets ____ Quilts or comforters ____ Other _____

Mattress: How old _____ Made of: Cotton ____ Foam ____ Encased ____ Other _____

Stuffed animals? Yes ____ No ____ Rugs: Carpet Yes ____ No ____ Type : Syntethic ____ Nylon ____

Home in General Heat: Gas ____ Oil ____ Electric ____ Space Heater ____ Other _____

Humidification: Good ____ Fair ____ Poor ____ Type: Furnace ____ Room ____ Vaporizer ____

Do you have electronic air filter: Yes ____ No ____

Is your basement Dry ____ Damp ____ Musty ____ Finished ____ Dehumidified: Yes ____ No ____

Do you have air conditioning? Yes ____ No ____ Type: Room ____ Central ____

Does anyone smoke in the home? Yes ____ No ____

Locations of previous residences:

City	Symptoms better, worse, or the same
_____	_____
_____	_____
_____	_____

Explain any unusual allergy exposures at home or work: Dust, fumes, odors, sawdust, fertilizers, paint, etc. _____

Have you had any previous allergy tests and/or treatments? Yes ____ No ____ If so, where and by whom:
