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:

_____

_____