HEARTWISE

A wholehearted approach to living.™

Appointment Preparation Instructions

1. Fasting

- You may drink water, however please avoid all other beverages for eight (8) hours prior to your visit
- Please refrain from eating for eight (8) hours prior to your visit
- Take medications as you normally would with water
- You are welcome to bring a snack to eat after the fasting portions of your tests have been completed. We will also have snacks, drinks, and coffee on hand for you.

2. Shoes

- Please bring footwear that is appropriate for a slow 3 minute walk on a treadmill

3. Medical History - Critical!

- Please fill out the attached Patient Medical History forms as much as possible prior to your appointment. While we recognize that everyone has filled out medical history paperwork before, we still encourage you to fill this out! We do review everything in detail and we use all of the information you provide.

  This may be one of the most comprehensive evaluations you have ever received, and having this snapshot of your health and medical history can be extremely useful for you at later times in your life, as well as to your children and grandchildren for their own health.

Medical History Reviewed By:

_____

Medical Provider Signature

HEARTWISE

A wholehearted approach to living.™

Patient Packet

Please complete this form and bring it with you to your appointment.

If you are unable to answer any questions, please let our staff know, and they will help you complete it.

A detailed family medical history can help our medical providers interpret the history of disease in your family and identify patterns that may be relevant to your own health. This form will help assess your risk of certain diseases, determine which diagnostic test to order as well as type and frequency of screening tests, identify a condition that might not otherwise be considered, and assess your risk of passing a condition on to your children.

Legal Name: _____ *Note: Write name as it appears on Government issued ID*

Date of Birth: ____/____/____ Gender (circle one): Male Female

Address: _____ City: _____ State: _____ Zip: _____

Primary Phone (cell): ( ) _____ - _____ Alternate Phone: ( ) _____ - _____

Email address: _____

**All contact information is kept confidential and is not shared*

Marital Status: ☐ Single ☐ In a relationship ☐ Married ☐ Divorced ☐ Widow/Widower ☐ _____

Living Situation: ☐ Alone ☐ Significant Other ☐ Relative ☐ Children ☐ _____

Heritage: ☐ African American, Hispanic or Indian Sub-continent (India, Pakistan, Sri Lanka, etc.) ☐ Caucasian ☐ Asian

Occupation/Company you work for: _____ Title: _____

DIAGNOSTIC TEST(S), PROCEDURES, SURGERY HISTORY

List any past health-related testing, diagnostic tests, hospital visits, procedures or surgeries.

Do not write "My physician has copies of all tests"

Type	Current Problem	Past Problem	Date of Test/Procedure/Surgery	Physician or Hospital
Example: Cath Procedure		X	May 11, 1999	Dr. Smith
E.g. Allergy Testing / DNA Testing				

Comments/Notes:

_____

_____

DIAGNOSIS / MEDICAL PROBLEMS IDENTIFIED

List all medical problems you have ever had at any time, including current problems. Include all diseases or illnesses you have been told you have or for which you have received treatment or taken medications or supplements for.

Condition:	Current Problem	Past Problem	Date when first diagnosed:	Date resolved or discontinued medication:
Example: Psoriasis	X		June 14, 1996	Currently on Enbrel
E.g. Allergies				
E.g. Pain				

Patient Name:_____ Date of Birth:_____

PERSONAL MEDICAL HISTORY

Check ALL that apply and circle the issues that trouble you the most.

	Yes	No	Explain/Clarify		Yes	No	Explain/Clarify
General				**Other**			
High cholesterol				Fever or chills			
High blood pressure				Recent weight change			
Elevated Sugar Levels or Diabetes				Heat or cold intolerance			
Problems sleeping				**Head and Neck**			
Family history of cancer				Swelling in neck			
Depression, bipolar or mental health issues				Prolonged hoarseness			
Ever taken pain or opioid medications				Frequent sore throat			
Taking any medications for 1+ year(s)				Pain or stiffness in neck			
Seasonal Allergies				**Eyes**			
Other allergies (med's, stings, food)				Glasses or contacts			
Other allergies (dust, smoke)				Double, failing vision			
Constipation				Dry eyes			
Diarrhea				Pain or light sensitivity			
Fatigue				**Ears, Nose, Mouth**			
Chronic fatigue				Loss of smell			
Cough				Nose bleeds			
Glaucoma				Sinus Problems			
AIDS/HIV				Runny Nose			
Cataracts				Postnasal drip			
Tuberculosis				Earache or drainage			
Kidney disease				Hearing loss			
Positive TB Test				Ringing in ears			
Aseptic necrosis				Sores in mouth			
Peptic (stomach) ulcer							
Osteoporosis				**Urogenital**			
Musculoskeletal				Frequent urination			
Swollen or red joints				Burning or painful urination			
Poor leg circulation				Blood in urine			
Arm or leg weakness				Bladder infections			
Leg cramps				Incontinence, dribbling			
Difficulty in walking				Kidney stones			
Arthritis				Sexual dysfunction			
Inflammatory Disease (e.g. psoriasis)				Irregular menses (female only)			

Patient Name:_____ Date of Birth:_____

PERSONAL MEDICAL HISTORY

Check ALL that apply and circle the issues that trouble you the most.

	Yes	No	Explain/Clarify
Neurological			
Light head or dizziness			
Speech disturbances			
Convulsions or seizures			
Numbness or tingling			
Frequent headaches			
Memory loss			
Paralysis or weakness			
Lungs			
Cough with sputum or blood			
Wheezing			
Asthma			
Short of breath at rest			
Short of breath with exercise			
Short of breath lying down			
Cardiovascular			
Heart failure			
Heart murmur			
Chest pain or Angina			
Heart skips beats			
Heart beats too fast			
Passing out spells			
Rheumatic fever			
Feet, ankle or leg swelling			

	Yes	No	Explain/Clarify
Gastrointestinal			
Abdominal pain			
Rectal bleeding			
Blood in stool			
Loss of appetite			
Heartburn or indigestion			
Black or tarry stools			
Frequent diarrhea			
Difficulty swallowing			
Nausea or vomiting			
Vomiting of blood			
Chronic constipation			
Endocrine			
Night sweats			
Excessive thirst			
Psychiatric			
Depression			
Anxiety			
Nervous breakdown			
Alcohol problems			
Physical, verbal, sexual abuse			
Recent changes in mood			

Please include any other conditions you would like to discuss with our medical provider:

Patient Name:_____ Date of Birth:_____

MEDICATIONS AND SUPPLEMENTS

List **all** prescription and over-the-counter medications/supplements you're currently taking or have ever taken. Include oral, inhaled, and injected medications/supplements, as well as drops, sprays, suppositories, creams and ointments.

Medication/Supplements:	Dosage/Frequency:	Reason for taking:	Date started:
Example: Suboxone	50 mg once per day	Drug withdrawal	March 2015

Comments/Notes:

FAMILY HISTORY

Please provide as much detail as you are able: Adopted: ☐ Yes ☐ No

We understand you may not have all information!

Indicate approximate age when diagnosis was first made:	Mom	Dad	Sister	Brother	Daughter	Son	Grandparents MGF/MGM PGF/PGM	Comments:
Example: Stroke	42		30				MGM-62	
High blood pressure								
High cholesterol								
Diabetes (I & II)								
Cancer								
Heart attack								
Heart failure								
Heart surgery/stent								
Angina (heart pain)								
Leg circulation problem								
Failing kidneys								
Stroke								
Smoking								
Dementia/Alzheimer's								
Alcoholism								
Arthritis								
Birth defects								
Hearing problems								
Sudden death								
Genetic disease								

Note: MGF=Maternal Grandfather, MGM=Maternal Grandmother, PGF=Paternal Grandfather, PGM=Paternal Grandmother

Please include any other details related to your family history:

Patient Name:_____ Date of Birth:_____

Cancer Risk Questionnaire

Do you have any Ashkenazi Jewish ancestry? ☐ Yes ☐ No

Have you or any member of your family, including distant relatives, have or ever had any kind of cancer? ☐ Yes ☐ No *

*** If No, do NOT fill out remaining Cancer Risk Questionnaire (skip pages 7 and 8)**

Have you ever been diagnosed with cancer?

☐ Yes ☐ No If yes, what type and at what age: _____

Any other personal cancer history or colon polyps?

☐ Yes ☐ No If yes, how many and when found: _____

What country did your mother's family come to the USA from? _____

What country did your father's family come to the USA from? _____

Have either of Parents ever had or currently have have cancer? ☐ Yes ☐ No **(If no, skip to next section)**

					Type of cancer	Age at diagnosis:
Mother	☐	Living-age:	☐	Deceased-age:		
Father	☐	Living-age:	☐	Deceased-age:		

Have either of grandparents ever had or currently have have cancer? ☐ Yes ☐ No **(If no, skip to next section)**

					Type of cancer	Age at diagnosis:
Mother's mother	☐	Living-age:	☐	Deceased-age:		
Mother's father	☐	Living-age:	☐	Deceased-age:		
Father's mother	☐	Living-age:	☐	Deceased-age:		
Father's father	☐	Living-age:	☐	Deceased-age:		

Do you have children that have or ever had cancer? ☐ Yes ☐ No **(If no, skip to next section)**

Relation					Type of cancer	Age at diagnosis:
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		

Do you have siblings that have or ever had cancer? ☐ Yes ☐ No **(If no, skip to next section)**

Relation (e.g. Brother, Sister)					Type of cancer	Age at diagnosis:
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		
	☐	Living-age:	☐	Deceased-age:		

Patient Name:_____ Date of Birth:_____

Cancer Risk Questionnaire

Do you have any nieces or nephews that have or ever had cancer? ☐ Yes ☐ No **(If no, skip to next section)**

Relation (how related to you, e.g. "brothers daughter")					Type of cancer	Age at diagnosis:
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			

Do you have any aunts or uncles that have or ever had cancer? ☐ Yes ☐ No **(If no, skip to next section)**

Relation (how related to you, e.g. "Father brother")					Type of cancer	Age at diagnosis:
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			

Any other family members that have or ever had cancer that wasn't included in the categories above?
(e.g. cousins, great-grandparents, great aunt/uncle etc) ☐ Yes ☐ No

Please state how you are related, for example: "Mother's younger sister's daughter, maternal grandmother's brother"

Relation					Type of cancer	Age at diagnosis:
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			
	☐ Living-age:		☐ Deceased-age:			

Any other cancer-related concerns or information regarding your family or your personal history?

_____

_____

_____

Internal Purposes Only

History reviewed by (Provider Signature): _____

Patient Name:_____ Date of Birth:_____

PGX Questionnaire

Do you currently have, have you had in the past, have you ever been treated for or taken any medications for any of the following conditions?

Bi-polar disorder	☐ Yes	☐ No	
Depression	☐ Yes	☐ No	
Huntington's disease	☐ Yes	☐ No	
Heart problems	☐ Yes	☐ No	If yes, specify: _____
Attention deficit hyperactivity disorder (ADHD)	☐ Yes	☐ No	
Hypothyroidism	☐ Yes	☐ No	
Diabetes (elevated sugar levels)	☐ Yes	☐ No	

Are you currently taken or have you ever taken any of the following?

Antithrombotic or antiplatelet medication	☐ Yes	☐ No
Opiate medications	☐ Yes	☐ No
Any long-term treatment/medication relating to pain	☐ Yes	☐ No

1. Have you had any medications that did not work well for your condition and that you or your medical provider subsequently had to change?
   ☐ Yes ☐ No
2. Have you ever experienced any reactions or sensitivities or allergies or any kind of side effects to medications prescribed to you by a medical provider? If so, list here or make sure medications are listed under "Medications and Supplements" on page 10.
   ☐ Yes ☐ No _____
3. Do you take or have you ever taken medications that did not relieve your symptoms?
   ☐ Yes ☐ No If yes, specify: _____
4. Have you ever taken or do you currently take any medications classified as a "controlled substance"?
   ☐ Yes ☐ No
5. Do any of the medications you have previously taken or are currently taking have a "warning" in the package insert?
   ☐ Yes ☐ No
6. Do you suspect or have you ever been told that any medications you take could have adverse reactions to each other?
   ☐ Yes ☐ No If yes, specify: _____

Critical Medications

Are you currently taking, have you ever taken or have you ever been prescribed any of the following:

Elavil/amitriptyline	☐ Yes	☐ No	Luvox/fluvoxamine	☐ Yes	☐ No
Abilify/aripiprazole	☐ Yes	☐ No	Razadyne/galantamine	☐ Yes	☐ No
Strattera/atomoxetine	☐ Yes	☐ No	Fanapt/iloperidone	☐ Yes	☐ No
Coreg/carvedilol	☐ Yes	☐ No	Tofranil/imipramine	☐ Yes	☐ No
Celebrex/celecoxib	☐ Yes	☐ No	Lopressor/metoprolo	☐ Yes	☐ No
Evoxac/cevimeline	☐ Yes	☐ No	Provigil/modafinil	☐ Yes	☐ No
Celexa/citalopram	☐ Yes	☐ No	Pamelor/nortriptyline	☐ Yes	☐ No
Onfi/clobazam	☐ Yes	☐ No	Protonix/pantoprazole	☐ Yes	☐ No
Anafranil/clomipramine	☐ Yes	☐ No	Trilafon/perphenazine	☐ Yes	☐ No
Plavix/clopidogrel	☐ Yes	☐ No	Rythmol/propafenone	☐ Yes	☐ No
Clozaril/clozapine	☐ Yes	☐ No	Vivactil/protriptyline	☐ Yes	☐ No
Tylenol #3/codeine	☐ Yes	☐ No	Nuedexta/quinidine/dextromethorphan	☐ Yes	☐ No
Norpramin/desipramine	☐ Yes	☐ No	Aciphex/rabeprazole	☐ Yes	☐ No
Valium/diazepam	☐ Yes	☐ No	Risperdal/risperidone	☐ Yes	☐ No
Sinequan/doxepin	☐ Yes	☐ No	Dexilant/dexlansoprazole	☐ Yes	☐ No
Nexium/esomeprazole	☐ Yes	☐ No	Soma/carisoprodol	☐ Yes	☐ No
Ansaid/flurbiprofen	☐ Yes	☐ No			

Note: all information is kept strictly <u>CONFIDENTIAL</u> and protected under federal HIPAA confidentiality laws.

Patient Name:_____ Date of Birth:_____

Allergy and Environmental Questionnaire

Do you have any kind of allergies to food, seasonal/environmental, dust? ☐ Yes ☐ No *

Have you ever had any skin reactions or hives or bumps or discoloration? ☐ Yes ☐ No *

* If No to BOTH questions above, do NOT fill out remaining Allergy & Environmental Questionnaire (skip pages 10, 11 and 12)

A. COMMON IRRITANTS AND ISSUES - Do you have any of the below in #1? ☐ **Yes** ☐ **No** **(If no, skip to next section.)**

1. Check all that apply **and circle** the ones that bother you the most:

Nose:	Throat:	Ears	Eyes	Head
☐ itchy nose	☐ sore throat	☐ itchy ears	☐ itchy eyes	☐ headache
☐ sneezing	☐ itchy throat or palate	☐ plugged ears	☐ watery eyes	☐ facial pressure or pain
☐ congestion	☐ throat clearing	☐ ringing	☐ red eyes	
☐ decreased smell/taste	☐ cough	☐ hearing loss	☐ dry/irritated eyes	
☐ snoring	☐ hoarseness		☐ swollen lids	
☐ runny nose - if yes, is the nasal discharge: ☐ clear ☐ colored	☐ post-nasal drainage - if yes, is the drainage: ☐ clear ☐ colored		☐ discharge	

2. Are your symptoms: ☐ seasonal* ☐ all year long ☐ all year long, with seasonal worsening*
Circle the **worst months:* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

3. Check the conditions or items that make your symptoms worse:

Irritants	Weather	Medicine	Allergens	Location	Other
☐ smoke	☐ cold air	☐ aspirin	☐ grass	☐ outdoors	
☐ air pollution	☐ rapid temperature change *(e.g. going from cold outdoors to indoor heat)*	☐ non-steroidal anti-inflammatory agents *(e.g. Motrin Advil, Aleve)*	☐ dust or vacuuming	☐ indoors	
☐ fumes or car exhaust			☐ damp or musty area	☐ daycare	
☐ strong odors or perfumes			☐ animals, if so, specify _____	☐ home	
				☐ school	
				☐ work	

4. Have you had any of the following **problems** or **procedures**: **If yes, specify* ☐ **Yes*** ☐ No
☐ frequent ear infections ☐ PE tubes ☐ nasal or sinus issues ☐ nasal polyps
☐ broken nose ☐ frequent sinus infections (how many in a year?____)

B. Have you ever had a reaction to a stick, drug/supplement, food or other substance? ☐ **Yes** ☐ **No** **(If no, skip to next section.)**

1. **What** did you react to? _____
If stung, **where** on your body were you stung? _____
2. **When** did the reaction occur? (approximate date) _____
3. **Length of time** from exposure (sting/injection) until onset of symptoms: _____
5. Briefly **describe** the reaction: _____
_____

6. Please check any of the following **symptoms** you had with your reaction:
☐ shortness of breath ☐ tongue swelling ☐ hoarseness or change in voice
☐ dizziness of loss of consciousness ☐ wheezing or chest tightness ☐ throat tightness or trouble swallowing
☐ flushing ☐ abdominal cramping, diarrhea or vomiting

7. Did you get **medical attention**? ☐ **Yes*** ☐ No
**If yes, was it from:* ☐ Emergency Room ☐ Urgent Care ☐ Clinic ☐ 911/Medics

8. **Treatment** (if any) you received: _____

9. Do you have a **current EpiPen**? ☐ Yes ☐ No

Patient Name:_____ Date of Birth:_____

Allergy and Environmental Questionnaire

C. Do you have any chest, breathing or asthma issues? ☐ **Yes** ☐ **No** **(If no, skip to next section.)**

1. Check all that apply **and circle** the ones that bother you the most:

___ shortness of breath ___ coughing up blood ___ asthma	___ wheezing ___ recurrent/chronic cough if yes, is the cough: ___ wet/productive ___ dry	___ chest pain or tightness

2. When did your symptoms **first** begin? _____ When, if so, did they **get worse**? _____
3. Are your symptoms: ☐ seasonal* ☐ all year long ☐ all year long, with seasonal worsening*
   Circle the **worst months :* Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec
4. **How often** do you have symptoms? ☐ 2 or less times a week ☐ once a day ☐ 3-6 times a week ☐ throughout the day
5. Do these symptoms **disturb your sleep**? ☐ **Yes*** ☐ No
   *If yes, how often? ☐ 2 or less times a month ☐ 3-4 times a month ☐ 2-6 times a week ☐ every night
6. Do your symptoms ever **interfere with exercise** or **daily activities**? ☐ **Yes*** ☐ No
   *If yes, what activity? _____
7. Have your symptoms forced you to **miss work** or **school**? (Circle which one) ☐ **Yes*** ☐ No
   *If yes, how many times in the past 12 months? _____
8. Have your symptoms caused you to go to the **Emergency Room** or **Urgent Care**? ☐ **Yes*** ☐ No
   *If yes, how many times in the past 12 months? _____
9. Have your symptoms caused you to be **admitted** overnight to the hospital? ☐ **Yes*** ☐ No
   *If yes, how many times? _____ Were you ever in the Intensive Care Unit? ☐ Yes ☐ No
   Have you been intubated or on a ventilator? ☐ Yes ☐ No
10. Have you ever needed treatment with an oral or injectable **steroid**? *(e.g. prednisone)* ☐ **Yes*** ☐ No
    *If yes, when was your last course of steroids? _____
11. Check the things that make your **chest symptoms worse**:

Irritants	Infections	Weather	Medicine	Allergens	Location	Other
___ smoke ___ fumes or car exhaust ___ air pollution ___ strong odors or perfumes	___ colds or flu ___ sinus infections	___ cold air ___ weather changes ___ heat	___ aspirin ___ non-steroidal anti-inflammatory agents *(e.g. Motrin Advil, Aleve)*	___ grass ___ dust or vacuuming ___ damp or musty area ___ animals, if so, specify _____	___ outdoors ___ indoors ___ daycare ___ home ___ school ___ work	___ exercise ___ emotion/stress ___ laughing ___ other: _____

12. Have you ever had pneumonia? ☐ **Yes*** ☐ No *If yes, how many times? _____
13. Have you had a **chest x-ray** since your symptoms began? ☐ **Yes*** ☐ No *If yes, when? _____
14. Do you have symptoms of **heartburn** or **acid reflux**? ☐ **Yes*** ☐ No *If yes, how often? _____
15. If you've been prescribed albuterol or have asthma, please answer the following questions:
    1. How many **puffs** of albuterol do you use **per day**? _____
    2. How many **canisters** of albuterol do you use **each month**? _____
    3. Do you use a **spacer** with your inhalers? ☐ Yes ☐ No
    4. Do you monitor your **peak flows**? ☐ **Yes*** ☐ No
       If yes, what is your **personal best peak flow**? _____
       What has been the **range** of your best peak flow readings over the past **2 weeks**? _____

D. Do you have eczema, psoriasis or any other skin condition? ☐ **Yes** ☐ **No** **(If no, skip to next section.)**

1. When did your eczema/psoriasis **first** begin? _____ When, if so, did it **get worse**? _____
2. What **parts of your body** are most affected? _____
3. Are your symptoms: ☐ seasonal* ☐ all year long ☐ all year long, with seasonal worsening*
4. Check all the things that make your **eczema/psoriasis worse**:

Irritants		Allergens		Foods		Other
___ soaps	___ tight clothing	___ dust	___ mold	___ milk	___ eggs	Infection: _____
___ detergents	___ cosmetics	___ pollen		___ wheat	___ soy	
___ wool	___ sun	___ animals: _____		___ nuts	___ peanuts	
___ heat		_____		___ other: _____		

Patient Name:_____ Date of Birth:_____

Allergy and Environmental Questionnaire

E. Do you have or ever get hives or swelling? ☐ **Yes** ☐ **No** **(If no, skip to next section.)**

1. What is your main **problem**? ☐ hives ☐ swelling ☐ hives and swelling
2. What **parts of your body** are affected? _____
3. When did your symptoms **first** begin? _____ When was your **last outbreak**? _____
4. On the average, **how long** does each outbreak last? _____
5. **How often** do outbreaks occur? ☐ daily ___ times a week ___ times a month ___ times a year
6. **If you have hives, how long** does each individual hive last? ☐ less than 24 hours ☐ more than 24 hours
7. Check any **symptoms you have with hives**: ☐ itching ☐ burning ☐ tingling ☐ pain ☐ bruising
8. Check all that apply:
   - Symptoms worse in the: ☐ spring ☐ summer ☐ autumn ☐ winter
   - Symptoms worse in the: ☐ morning ☐ afternoon ☐ evening ☐ night
   - Symptoms worse in the: ☐ outdoors ☐ indoors ☐ home ☐ school ☐ daycare ☐ work
   - Symptoms worse during: ☐ weekdays ☐ weekends ☐ menstrual cycle
9. During an outbreak, do you have any of the following **symptoms**? ☐ **Yes*** ☐ No **If yes, check box.*
   - ☐ shortness of breath ☐ flushing ☐ tongue swelling ☐ throat tightness or trouble swallowing
   - ☐ wheezing or chest tightness ☐ hoarseness or change in voice ☐ dizziness or loss of consciousness
   - ☐ joint pain ☐ fever ☐ swollen glands ☐ diarrhea, vomiting or abdominal pain
10. Check all the things that make your **symptoms worse**:

Exposure to:	Medicines:	Allergens:	Other:
☐ exercise	☐ aspirin	☐ grass	☐ emotion or stress
☐ cold air	☐ non-steroidal	☐ dust or vacuuming	☐ other:
☐ sunlight	☐ anti-inflammatory agents (e.g. Motrin, Advil, Aleve)	☐ wooded areas	_____
☐ heat (shower/bath)	☐ ACE inhibitors (e.g. lisinopril)	☐ damp or musty areas	_____
☐ rubbing or scratching vibration (mowing lawn, motorcycling)	☐ other medicines: _____	☐ latex (balloons, condoms, dental work, latex gloves)	
		☐ foods or food additives: _____	

11. Check the box if the following **events** happened soon before your symptoms started:
   - ☐ mononucleosis ☐ jaundice or hepatitis ☐ impetigo or skin infection
   - ☐ swollen lymph glands ☐ urinary tract infection ☐ sinus infection
   - ☐ pneumonia ☐ thyroid problems ☐ bee sting
   - ☐ fungal infection of skin, scalp or nails ☐ sore throat or strep throat
   - ☐ transfusion ☐ toothache or gum infection
   - ☐ change of residence ☐ ulcers or gastritis
   - ☐ recent move from another area; from where? _____
   - ☐ foreign travel, where? _____
   - ☐ immunization, specify: _____
   - ☐ job change, specify: _____
   - ☐ other: _____

F. ALLERGY HISTORY

1. Have you have previous allergy **skin testing**? ☐ **Yes*** ☐ No **If yes, when?* _____
2. Have you ever received **allergy shots**? ☐ **Yes*** ☐ No **If yes, specify the years you received them:*
   From _____ to _____ Additional years: From _____ to _____ From _____ to _____
   Were the shots helpful? ☐ Yes ☐ No Did you have any bad reactions? ☐ Yes ☐ No
3. Have you used nasal sprays? ☐ Yes ☐ No
4. Have you used antihistamines? ☐ Yes ☐ No
3. Do you have allergies to any foods? ☐ **Yes*** ☐ No **If yes, specify:*

Name of food	Allergic reaction(s)	Approx. date of reaction(s)