MIDWEST
EAR, NOSE & THROAT
ALLERGY CENTER
2315 W. 57th Street • Sioux Falls, SD 57108
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www.midwestent.com

NAME: _____

DATE: _____ PT ID#: _____

HOME #: _____ WORK #: _____

CELL #: _____

AGE: _____ AGE AT WHICH SYMPTOMS BEGAN: _____

SYMPTOMS: *(Indicate from the list below)*

❑ Cough	❑ Wheezing	❑ Ears popping	❑ Fatigue	❑ Abdominal pain/gas
❑ Colds	❑ Red/watery eyes	❑ Ear infections	❑ Rashes/hives	❑ Hoarseness
❑ Sneezing	❑ Itchy eyes	❑ Headaches/migraines	❑ Nausea	❑ Scratchy throat
❑ Runny nose	❑ Itchy mouth	❑ Sinusitis	❑ Indigestion	❑ Post Nasal Drainage
❑ Nasal congestion	❑ Dizziness	❑ Fever	❑ Diarrhea	

List your top three symptoms starting with the most bothersome.

1. _____ 2. _____ 3. _____

FREQUENCY/TIME OF SYMPTOMS: *(Check corresponding boxes below)*

My symptoms are worse: ❑ Spring ❑ Summer ❑ Fall ❑ Winter ❑ No pattern

SURROUNDINGS/EXPOSURE:

Non-Allergic triggers that I feel cause my symptoms:

❑ Tobacco Smoke	❑ Home Cleaning Supplies	❑ Cold Air
❑ Foods	❑ Gas/Diesel Fumes	❑ Medications
❑ Perfumes	❑ Auto Exhaust	❑ Heat/Humidity
❑ Potpourri	❑ Weather Changes	

Do you smoke? ..... ❑ Yes ❑ No

LIST TYPE OF:

Home _____ (single family, apt/condo, mobile home)

Heating system_____ (central, gas, electric, etc)

Floor coverings _____ (carpet, wood, linoleum, etc.)

Pillows _____ (foam, feather, cotton)

Mattress _____ (cotton, feather, foam rubber, waterbed)

PETS: *(Indicate animals you are frequently exposed to)*

❑ No Pets

❑ Dog ..... ❑ Indoor ❑ Outdoor How many? _____ What breed?_____

❑ Cat ..... ❑ Indoor ❑ Outdoor How many? _____ What breed?_____

❑ Horse

Do your pet(s) go into your bedroom? ❑ Yes ❑ No

❑ Other_____ ❑ Indoor ❑ Outdoor

History of severe reactions or anaphylaxis:

❑ Never	❑ Bee/Wasp Stings	❑ Shellfish
❑ Peanut	❑ Other Foods	❑ Medications
❑ Other:_____		

PREVIOUS ALLERGY TESTING:

Have you ever been tested for allergies? ❑ Yes ❑ No ❑ Skin Testing or ❑ Blood Testing

If Yes, please list When:_____ Where: _____

If Yes, were you treated with shots or drops? _____ When did you start taking them? _____

How long was your treatment for? _____ years

Did you get any relief from your treatment? ❑ Significant Improvement
❑ Moderate Improvement
❑ Little or No Improvement

I have been allergy tested before and found to be allergic to:

❑ All Negative

❑ Dust ❑ Trees ❑ Grasses
❑ Weeds ❑ Molds ❑ Animals
❑ Foods

FAMILY HISTORY: *(Indicate members of your family who have been tested for allergies and are positive)*

❑ Mother ❑ Sister ❑ Grandmother ❑ Child ❑ Adopted
❑ Father ❑ Brother ❑ Grandfather

MEDICAL HISTORY: *(Check if **you** now have or have ever been diagnosed with)*

❑ Diabetes
❑ Heart Trouble
❑ High Blood Pressure
❑ Stroke
❑ Bleeding Disorders
❑ Kidney or Liver problems
❑ Arthritis
❑ HIV/AIDS
❑ Chronic Lung Disease
❑ Depression
❑ Cancer
❑ Seizure Disorder
❑ Migraines
❑ Bronchitis
❑ Thyroid Problems
❑ Psychiatric Disorders
❑ Sleeping Disorders
❑ Other: _____
_____

Please circle ONE that applies:

- Currently have Asthma
- Had Asthma but "outgrew" it
- Never had Asthma

Doctor taking care of Asthma _____

***Women:** Are you pregnant now or think you may be? ❑ Yes ❑ No

MEDICATIONS:

Medications I have used for my nasal symptoms: ❑ Antihistamine (example: Zyrtec, Benadryl, Allegra, Claritin)
❑ Decongestant (example: Sudafed)
❑ Singulair
❑ Nasal Steriods (example: Nasonex, Flonase, Veramyst, Nasocort, Rhinocort)

Antihistamines provide me: ❑ Little or No Relief ❑ Moderate Relief ❑ Near to Total Relief

Decongestants provide me: ❑ Little or No Relief ❑ Moderate Relief ❑ Near to Total Relief

I am interested in being tested for: ❑ Pollens ❑ Molds ❑ Animals ❑ Other _____

Signature: _____ Date: _____
(Patient or Guardian)