**Part 1: Please answer only the sections that apply to you**

**Age:** ______  **Sex:**  □ Male  □ Female  
**Birthplace:** ______  **Years in Northwest:** ______  
**Your main concerns:** ___________________________________________________________

---

**Complete this section only for: NOSE / THROAT / EARS / EYES / HEAD SYMPTOMS**  
*If none, skip to next section*

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

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Nose</th>
<th>Throat</th>
<th>Ears</th>
<th>Eyes</th>
<th>Head</th>
</tr>
</thead>
<tbody>
<tr>
<td>itchy nose</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>sneezing</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>congestion</td>
<td>□</td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>decreased smell/taste</td>
<td></td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>snoring</td>
<td></td>
<td>□</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>runny nose - if yes, is the nasal discharge:</td>
<td>□ clear □ colored</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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) Check the things that make your symptoms worse:  

<table>
<thead>
<tr>
<th>Irritants</th>
<th>Weather</th>
<th>Medicine</th>
<th>Allergens</th>
<th>Location</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>smoke</td>
<td>□ cold air</td>
<td>□ aspirin</td>
<td>□ grass</td>
<td>□ outdoors</td>
<td></td>
</tr>
<tr>
<td>air pollution</td>
<td>□ rapid temperature change (e.g. going from cold outdoors to indoor heat)</td>
<td>□ non-steroidal anti-inflammatory agents (e.g. Motrin, Advil, Aleve)</td>
<td>□ dust or vacuuming</td>
<td>□ indoors</td>
<td></td>
</tr>
<tr>
<td>fumes or car exhaust</td>
<td>□ strong odors or perfumes</td>
<td>□ nasal or sinus surgery</td>
<td>□ damp or musty area</td>
<td>□ daycare</td>
<td></td>
</tr>
<tr>
<td>exhaust</td>
<td>□ broken nose</td>
<td>□ nasal polyps</td>
<td>□ animals, if so specify: ______</td>
<td>□ home</td>
<td></td>
</tr>
<tr>
<td>strong odors or perfumes</td>
<td>□ frequent sinus infections (how many in a year? ______)</td>
<td>□ frequent sinus infections</td>
<td>□ animals</td>
<td>□ school</td>
<td></td>
</tr>
</tbody>
</table>

5) Have you had any of the following problems or procedures:  

*If yes, specify*  □ Yes*  □ No  

□ frequent ear infections  □ PE tubes  □ nasal or sinus surgery  □ nasal polyps  
□ broken nose  □ frequent sinus infections

---

**Complete this section if: ALLERGIC REACTION TO A STING, DRUG, FOOD or other SUBSTANCE**  
*If none, skip to next section*  
If more than one reaction: answer the same questions for each reaction on a separate page

1) What did you react to? ____________________________________________  
   If stung, where on your body were you stung? ________________________

2) When did the reaction occur? (date and time of day) __________________

3) Length of time from exposure (or sting/injection) until onset of symptoms: __________________

4) How long did your symptoms last? __________________

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 or 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
Complete this section only for: CHEST or ASTHMA SYMPTOMS  *If none, skip to next section

1) Check all that apply and circle the ones that bother you the most:
   □ shortness of breath   □ wheezing   □ chest pain or tightness   □ coughing up blood
   □ recurrent or chronic cough – if yes, is the cough: □ wet/productive   □ dry

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 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 visits 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:

<table>
<thead>
<tr>
<th>Irritants</th>
<th>Infections</th>
<th>Weather</th>
<th>Medicine</th>
<th>Allergens</th>
<th>Location</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>smoke</td>
<td>colds</td>
<td>cold air</td>
<td>aspirin</td>
<td>grass</td>
<td>outdoors</td>
<td>exercise</td>
</tr>
<tr>
<td>fumes/car</td>
<td>or flu</td>
<td>weather</td>
<td>non-steroidal</td>
<td>dust/vacuuming</td>
<td>indoors</td>
<td>emotion/</td>
</tr>
<tr>
<td>exhaust</td>
<td>sinus</td>
<td>changes</td>
<td>agents</td>
<td>damp or musty</td>
<td>home</td>
<td>stress</td>
</tr>
<tr>
<td>air pollution</td>
<td>infections</td>
<td>heat</td>
<td>(e.g. Motrin, Advil, Aleve)</td>
<td>areas</td>
<td>daycare</td>
<td>laughing</td>
</tr>
<tr>
<td>strong</td>
<td></td>
<td></td>
<td></td>
<td>animals,</td>
<td>school</td>
<td>other:</td>
</tr>
<tr>
<td>odors or</td>
<td></td>
<td></td>
<td></td>
<td>If yes, specify:</td>
<td>work:</td>
<td></td>
</tr>
<tr>
<td>perfumes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>___________</td>
<td></td>
</tr>
</tbody>
</table>

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? _____________

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 peak flow readings over the past 2 weeks? ____________

Complete this section only for: ECZEMA  *If none, skip to next section

1) When did your eczema 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?
   * Circle worst months: Jan Feb Mar Apr May Jun Jul Aug Sep Oct Nov Dec

4) Check the things that make your eczema worse:

<table>
<thead>
<tr>
<th>Irritants</th>
<th>Allergens</th>
<th>Foods</th>
<th>Other:</th>
</tr>
</thead>
<tbody>
<tr>
<td>soaps</td>
<td>dust</td>
<td>milk</td>
<td>Infection</td>
</tr>
<tr>
<td>detergents</td>
<td>pollen</td>
<td>nuts</td>
<td>________</td>
</tr>
<tr>
<td>wool</td>
<td>mold</td>
<td>soy</td>
<td></td>
</tr>
<tr>
<td>heat</td>
<td>animals:</td>
<td>wheat</td>
<td></td>
</tr>
<tr>
<td>tight clothing</td>
<td>cosmetics</td>
<td>eggs</td>
<td></td>
</tr>
<tr>
<td>heat</td>
<td>sun</td>
<td>peanuts</td>
<td></td>
</tr>
<tr>
<td>sun</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other:</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

DO NOT SCAN THIS QUESTIONNAIRE

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Continued on next page
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 the things that make your symptoms worse:

<table>
<thead>
<tr>
<th>Exposure to:</th>
<th>Medicines</th>
<th>Allergens</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>exercise</td>
<td>aspirin</td>
<td>grass</td>
<td>emotion or stress</td>
</tr>
<tr>
<td>cold air</td>
<td>non-steroidal</td>
<td>dust or vacuuming</td>
<td>other: ________</td>
</tr>
<tr>
<td>sunlight</td>
<td>anti-inflammatory agents</td>
<td>wooded areas</td>
<td></td>
</tr>
<tr>
<td>heat (shower/bath)</td>
<td>(e.g. Motrin, Advil, Aleve)</td>
<td>damp or musty area</td>
<td></td>
</tr>
<tr>
<td>rubbing or scratching</td>
<td>ACE inhibitors</td>
<td>latex (balloons, condoms, dental work, latex gloves)</td>
<td></td>
</tr>
<tr>
<td>vibration (mowing lawn, motorcycling)</td>
<td>(e.g. lisinopril)</td>
<td>animals, specify:</td>
<td></td>
</tr>
<tr>
<td>_________________________</td>
<td>other medicines:</td>
<td>foods or food additives</td>
<td></td>
</tr>
<tr>
<td>_________________________</td>
<td>_______________</td>
<td>specify: ________</td>
<td></td>
</tr>
</tbody>
</table>

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

Part 2: Please answer all of the remaining questions

Medicines

List all prescription and over-the-counter medicines you’re currently taking that you do not receive through Kaiser Permanente. Include oral, inhaled, injected, drops, sprays, suppositories, creams and ointments.

<table>
<thead>
<tr>
<th>Name of medicine</th>
<th>Strength (if known)</th>
<th>Dose and number of times taken per day</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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<tr>
<td></td>
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</tr>
</tbody>
</table>

Attach separate list if necessary.

Allergy History

1) Have you had 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 _______
   Were the shots helpful? □ Yes □ No Did you have any bad reactions? □ Yes □ No
3) Do you have allergies to any foods? □ Yes* □ No * If yes, specify:
   Name of food Allergic reaction(s) Approximate date of reaction(s)
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________
   ____________________________________________________________

DO NOT SCAN THIS QUESTIONNAIRE
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Past Medical History

1) Check the box if you've had any of the following:
   - glaucoma □
   - cataracts □
   - depression □
   - high blood pressure □
   - diabetes □
   - tuberculosis □
   - positive TB test □
   - peptic (stomach) ulcer □
   - AIDS or HIV □
   - kidney disease □
   - aseptic necrosis □
   - osteoporosis □
   - heart problems □
   - other significant medical problems: _________________________________

2) Please list all surgeries and hospital stays: (followed by approximate date)

<table>
<thead>
<tr>
<th>Medical Problem</th>
<th>Mother</th>
<th>Father</th>
<th>Brother</th>
<th>Sister</th>
<th>Son</th>
<th>Daughter</th>
<th>Grandmother</th>
<th>Grandfather</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asthma</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nasal allergy</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sinus problems</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eczema</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Family History

Please place a check mark for each relative with the following medical problems:

* If more than one relative has the same medical problem, place a check mark for each one.

Example: 2 brothers with asthma: Medical Problem Mother Father Brother

3) Have you ever smoked? □ Yes* □ No * If yes, specify.
   - Are you: □ a current smoker? □ a past smoker? Quit date: ________________
   - What and how long did you smoke? □ cigarettes: ____ years Packs per day: ________________
   - □ cigars: ____ years □ pipe: ____ years

4) Does anyone in your home smoke? □ Yes* □ No * If yes, specify.
   - mother □ father □ spouse or partner □ son □ daughter
   - □ brother □ sister □ roommate □ other: ________________

Environmental History

1) What is/was your occupation or, if you are still a student, your grade in school? ________________

2) What are your hobbies? ________________________________

3) How long have you lived at your present location? ____ years

4) Location: □ downtown □ urban □ suburb □ rural/country

5) Type of home: □ house □ apartment/condo □ houseboat □ mobile home □ other: ________________

6) Where do you live? (City, town, city neighborhood, or nearest city)? ________________

7) Type of heating: □ radiant □ forced air □ heat pump □ wood burning stove □ pellet stove □ other: ________________

8) Air conditioning: □ none □ central □ window units

9) Air filter: □ HEPA □ electrostatic

10) Floor: Bedroom: □ carpeting □ wood/laminate □ tile □ cement □ other: ________________
       Family room: □ carpeting □ wood/laminate □ tile □ cement □ other: ________________

11) Mattress: □ regular □ foam □ air mattress □ waterbed □ futon □ other: ________________

12) Pillow: □ synthetic □ foam □ down □ feather □ cotton □ other: ________________

13) Comforter: □ none □ down □ synthetic □ feather □ other: ________________

14) Do you have zipped dustmite allergy covers (encasements)? □ Yes* □ No * If yes, what item is covered?
   - pillows □ mattress □ comforter □ box springs

15) Do you have any pets? □ Yes* □ No * If yes, check all that apply and how many of each animal.
   - □ cat(s) #_____ □ dog(s) #_____ □ bird(s) #_____ □ guinea pig(s) #_____?
   - □ gerbil(s) #_____ □ hamster(s) #_____ □ rabbit(s) #_____ □ other: ________________

   Circle all pets that live in or have access to your (or the patient’s) bedroom.

16) Do you have a mold or mildew problem in your home? □ Yes* □ No *If yes, is it a □ minor problem? □ major problem?
   Where is it? □ bathroom □ basement □ kitchen □ window sills □ other: ________________

Thank you