DALLAS ASTHMA & ALLERGY CENTER

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Date: _____

Name of Patient: _____ Date of Birth: _____

Name of Guardian: _____ Relationship to patient: _____

Address: _____ City: _____ Zip: _____

Name of person who referred you: _____

What are your symptoms/problems: **Circle where applicable**:

Nose:	Itching	Running	Sneezing	Blocking	Nosebleeds
Eyes:	Itching	Running	Swelling	Redness	Blurring of vision
Ears:	Itching	Blocking	Infections	Ringing	Hearing loss
Throat:	Itching	Voice Loss	Infections	Postnasal Drip	
Chest:	Coughing	Wheezing	Infections	Shortness of Breath	Asthma
Headache:	Sinus	Migraine	Tension	Muscular	Other
Skin:	Hives	Eczema	Itching	Swelling	
Stomach:	Nausea	Cramps	Indigestion/ Heartburn	Diarrhea	Constipation
Other:	Fatigue	Fever	Infections	Loss of weight or appetite	

Which of the above are the most important to you? _____

When did these symptoms occur for the first time in your life? _____

Where were you living then? _____

Are the symptoms you circled? All year round or Seasonal – Spring, Summer, Fall, Winter

Are the symptoms? Mild Moderate Severe

Time missed from work/school: _____
Hospital visits or admissions: _____

(continued on reverse side)