Name________________________ Date_________________________

Have you ever been allergy tested? _______ When?________________________________

Name of doctor/facility that did testing: ____

What testing method was used?_______________Did you take injection treatment?________

List any food allergies or intolerances: ____

List any medication allergies or intolerances: _______________________________________

List all prescription medications you are taking; include the dose and how often (once-a-day, once-a-week, as-needed, etc.) flonase once a day, orthonovum_________________________________

____

____

List any over-the-counter medications, vitamins, or herbal remedies that you take now or occasionally; include the dose and how often (once a day, once a week, as needed etc.)_________

____

____

List other illness or accidents that required hospital admission; include the approximate date(s):

____

List any surgeries you have had; include the approx. date(s):___________________________

____

____

Do you smoke?_____ Cigarettes __Cigars__ How many a day? ____How many yrs/mos? ______

Family History:

List family members with any of the following:

Allergies___________________________	Heart Disease_______________________
Asthma____________________________	High Blood Pressure___________________
Eczema____________________________	Diabetes____________________________
Hives______________________________	Cancer_____________________________

Environment:

Home: Do you have central heat and air? ______________
How old are your mattresses? ________________
How old are your pillows_________, are they synthetic fiber or feather?________
List all pets.____

Work: What is your occupation? ____
Are you exposed to any fumes, smoke, dust, chemicals or animals at work? _____
If so, please describe.____