

David C. Redfern, M.D.
Cedar Valley Medical Specialists, P.C.
Department of Allergy and Immunology
1753 West Ridgeway Ave. Suite 106
Waterloo, IA 50702
Phone - 319-833-5982

Practice limited to Adult and Pediatric Allergy and Asthma

ANSWER ALL QUESTIONS AND STAY OFF ALL ANTIHISTAMINES & DECONGESTANTS INCLUDING NASAL SPRAYS FOR AT LEAST 48 HOURS PRIOR TO YOUR FIRST VISIT. IF YOU HAVE ANY QUESTIONS REGARDING MEDICATIONS, PLEASE CALL BEFORE DISCONTINUING MEDICATIONS. CONTINUE ASTHMA MEDICATION.

Patient Name _____ Date _____

Name and Address of referring Physician _____
(if applicable)

1. Mark an X after any of the following symptoms which have bothered you (patient) in the past:
Mark XX if severe and XXX if extremely severe.

- | | | |
|------------------------------|---------------------------|--------------------|
| _____ Coughing | _____ Nasal Blockage | _____ Sore Throat |
| _____ Wheezing | _____ Runny Nose | _____ Itchy Throat |
| _____ Shortness of Breath | _____ Sneezing | _____ Headache |
| _____ Skin Itching | _____ Post Nasal Drainage | _____ Eye Itching |
| _____ Skin Rash | _____ Itchy Nose | _____ Tearing |
| _____ Hives or Swelling | _____ Nose Bleeds | _____ Ear Fullness |
| _____ Loss of Taste or Smell | | |

Other (describe) _____

2. Which symptom is most bothersome? _____
When did it start? Month _____ Year _____

3. Are your symptoms worse during certain seasons? _____ Which seasons? _____
List the months when you feel worse _____

4. Do any of the following worsen your symptoms?
_____ When in air conditioning _____ After exposure to animals (which animals)
_____ During quick weather changes _____ On exposure to freshly mown grass
_____ When it rains _____ In fields or in tall weeds
_____ When you are indoors _____ On exposure to tobacco smoke
_____ In the morning after rising _____ On exposure to hair spray or perfumes
_____ When you are nervous or upset

5. How much time have you missed from school or work in the past 12 months (No. of days) _____

6. How many Emergency Room visits have you had in the past 12 months? _____

7. Have you ever had allergy skin tests and/or treatment? _____ By whom? _____
From _____ To _____ (Date of 1st & last inj.)
Did you have reactions? Local _____ General _____ Immediate _____ After 12 hours _____
Were you : Better _____ (percent) Worse _____ No Change _____?

8. Is there anyone among your relatives (grandparents, parents, uncles, aunts, brothers, sisters) who have or had hayfever, asthma, chronic cough, sinus trouble, migraine headaches, hives, or eczema?

Please list person involved and give condition: _____

9. Your home environment:

Age of the house _____ Carpeting _____ Damp/Musty areas _____ Air Conditioning _____ Pets _____

HEATING: " Forced Air " Radiator " Other

BED: " Regular " Waterbed PILLOWS: " Feather " Fiberfill " Foam

10. What did you and/or your doctor expect **us** to do first? _____

11. What type of work do you do?

Tobacco use: _____ Alcohol Use: _____

12. List all medications that you are **currently** taking/include dose.

MEDICATIONS

DOSE

13. List any medications to which you have had an allergic or adverse reaction:

MEDICATIONS

SYMPTOMS

14. Please list any questions you may have: _____

15. List hospitalizations, most recent first:

REASON HOSPITALIZED

DATES

16. List all serious past medical and surgical illnesses:

