NEW MEXICO
SINUS INSTITUTE
Ear, Nose & Throat Specialists

3791 Southern Blvd., Suite 100 | Rio Rancho, NM 87124 | Ph: 505.994.9435 | Fax: 505.896.9789

Patient Name: ______________________________ Today's Date: ___________
Date of Birth: ______________________________

Previous Allergy History
Medications: ____
Previous allergy testing? Y N If yes, by whom? _________________ Date:__________
Have you previously been on Immunotherapy? Y N When was it discontinued? _________

Allergy Review of Symptoms (Please check all that apply to today's visit)

Itchy Eyes		Stuffy Nose		Chronic Cough		Hives	
Watery Eyes		Sneezing		Chest Tightness		Rash	
Red Eyes		Runny Nose		Wheezing		Eczema	
Plugged Ears		Itchy Nose		Shortness of Breath		Facial Swelling	
Itchy Ears		Postnasal Drip		Chest Tightness w/exercise		Skin Itching	
Pressure in Ears		Frequent Colds		Sore Throat			

Which of the following worsen symptoms?

Spring		Mold		Cosmetics		Air Conditioning	
Fall		Animal Exposure		Stress		Viral Infections	
Summer		Pollution		Paint/Chemical Fumes		Perfumes	
Winter		Cleaning fluids		Fabric Softeners		Exercise	
Weather Change		Windy Conditions		Tobacco Smoke		Dust	
Temperature Change		Other:					

Living Conditions

Type of Home:	Do you have pets in home? If yes, what?
Heating:	Do you have down bedding?
Cooling:	Does your home have water leakage/mold growth?
Smoker: Y N # of packs per day: _______	If yes, where is leak/mold growth?

Family Allergy History (Have you or any family member experienced any of the following?)

Please Check all that apply	Patient	Mother	Father	Siblings	Any other pertinent family history:
Pollen allergies					
Hives					
Food allergies					
Celiac Disease					
Asthma					
Eczema					
Other:					