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DO YOU HAVE ALLERGIES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know What are you allergic to?		DO ANY OF YOUR BLOOD RELATIVES HAVE ALLERGIES? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know		NAME WHAT MEDICATIONS DO YOU TAKE DAILY OR FREQUENTLY? <input type="checkbox"/> Aspirin <input type="checkbox"/> Vitamins <input type="checkbox"/> Cortisone <input type="checkbox"/> Ointments <input type="checkbox"/> Laxatives <input type="checkbox"/> Nose Drops <input type="checkbox"/> Sedatives <input type="checkbox"/> Hormones <input type="checkbox"/> Birth Control pills <input type="checkbox"/> Other (list):		AGE BY DATE		NAME SEX
CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE OR HAD: <input type="checkbox"/> High blood pressure <input type="checkbox"/> Heart disease <input type="checkbox"/> Stomach or intestinal disease <input type="checkbox"/> Overactive thyroid <input type="checkbox"/> Underactive thyroid <input type="checkbox"/> Any hormonal difficulty <input type="checkbox"/> Migraine headache <input type="checkbox"/> Frequent headaches <input type="checkbox"/> Asthma <input type="checkbox"/> Sinus disease <input type="checkbox"/> Emphysema <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Bronchitis <input type="checkbox"/> Broken nose <input type="checkbox"/> Hay fever <input type="checkbox"/> Nasal surgery <input type="checkbox"/> Hives <input type="checkbox"/> Deviated septum <input type="checkbox"/> Skin disease <input type="checkbox"/> Food allergy <input type="checkbox"/> Drug allergy What drugs? <input type="checkbox"/> Other Conditions				DO YOU USE MEDICATION REGULARLY FOR NASAL SYMPTOMS? <input type="checkbox"/> Yes <input type="checkbox"/> No What is it? Does it help?		NOTES		
				HEATING SYSTEM <input type="checkbox"/> None <input type="checkbox"/> Electricity <input type="checkbox"/> Oil <input type="checkbox"/> Don't know <input type="checkbox"/> Gas <input type="checkbox"/> Other <input type="checkbox"/> Coal		PILLOW: MATTRESS: <input type="checkbox"/> None used <input type="checkbox"/> Cotton <input type="checkbox"/> Foam rubber <input type="checkbox"/> Foam rubber <input type="checkbox"/> Feather <input type="checkbox"/> Horse hair <input type="checkbox"/> Dacron <input type="checkbox"/> Feather <input type="checkbox"/> Don't know <input type="checkbox"/> Don't know <input type="checkbox"/> Other <input type="checkbox"/> Other		
				METHOD OF HEAT DELIVERY <input type="checkbox"/> Hot air blower <input type="checkbox"/> Radiators <input type="checkbox"/> Electric panels <input type="checkbox"/> Don't know		DO YOU USE HUMIDIFIERS? <input type="checkbox"/> Yes <input type="checkbox"/> No		
CHECK SYMPTOMS YOU USUALLY HAVE: <input type="checkbox"/> Itching of nose <input type="checkbox"/> Stuffy nose <input type="checkbox"/> Nose running <input type="checkbox"/> Sneezing <input type="checkbox"/> Post-nasal drip <input type="checkbox"/> Loss of smell <input type="checkbox"/> Eyes itch <input type="checkbox"/> Eyes water <input type="checkbox"/> Throat itch <input type="checkbox"/> Ear infection <input type="checkbox"/> Sore throat <input type="checkbox"/> Cough <input type="checkbox"/> Wheeze HOME: <input type="checkbox"/> House <input type="checkbox"/> City <input type="checkbox"/> Apt <input type="checkbox"/> County		YOUR ENVIRONMENT: OCCUPATION: Prominent materials used: At work, are your symptoms: <input type="checkbox"/> better <input type="checkbox"/> worse <input type="checkbox"/> same AIR CONDITIONING: <input type="checkbox"/> Bedroom <input type="checkbox"/> At work <input type="checkbox"/> Central <input type="checkbox"/> None		ANIMALS IN HOME: In past At present <input type="checkbox"/> Dog <input type="checkbox"/> Dog <input type="checkbox"/> Cat <input type="checkbox"/> Cat <input type="checkbox"/> Bird <input type="checkbox"/> Bird <input type="checkbox"/> Rodent <input type="checkbox"/> Rodent <input type="checkbox"/> Other <input type="checkbox"/> Other		Other animals you frequently contact:		
		ARE SYMPTOMS: <input type="checkbox"/> Constant <input type="checkbox"/> Erratic <input type="checkbox"/> Present most of the time <input type="checkbox"/> Present part of the time <input type="checkbox"/> Present rarely		DURING WHAT MONTHS DO YOU USUALLY HAVE SYMPTOMS? <input type="checkbox"/> All months <input type="checkbox"/> Jan <input type="checkbox"/> July <input type="checkbox"/> Feb <input type="checkbox"/> Aug <input type="checkbox"/> Mar <input type="checkbox"/> Sept <input type="checkbox"/> Apr <input type="checkbox"/> Oct <input type="checkbox"/> May <input type="checkbox"/> Nov <input type="checkbox"/> June <input type="checkbox"/> Dec		ARE SYMPTOMS WORSE: <input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening <input type="checkbox"/> Night <input type="checkbox"/> At home <input type="checkbox"/> At work <input type="checkbox"/> Other location		
SMOKING HABITS: Cigarettes # _____ /day Pipe # _____ /day Cigars # _____ /day Years Smoked _____ Stopped smoking in _____		SOME OF THE FOLLOWING MAY CAUSE YOUR SYMPTOMS OR MAKE THEM WORSE. CHECK THOSE THAT DO. <input type="checkbox"/> indoors <input type="checkbox"/> animals <input type="checkbox"/> milk or milk products <input type="checkbox"/> outdoors <input type="checkbox"/> cooking odors <input type="checkbox"/> eggs <input type="checkbox"/> Weather change <input type="checkbox"/> smoke <input type="checkbox"/> wheat products <input type="checkbox"/> Wet weather <input type="checkbox"/> soap powder <input type="checkbox"/> nuts, beans, or seeds <input type="checkbox"/> Dry weather <input type="checkbox"/> insecticides <input type="checkbox"/> chocolate <input type="checkbox"/> Windy day <input type="checkbox"/> paint fumes <input type="checkbox"/> fish <input type="checkbox"/> Hot day <input type="checkbox"/> perfumes <input type="checkbox"/> meat <input type="checkbox"/> Cold day <input type="checkbox"/> cosmetics <input type="checkbox"/> fruit <input type="checkbox"/> Air conditioning <input type="checkbox"/> wave sets <input type="checkbox"/> vegetables <input type="checkbox"/> In barns <input type="checkbox"/> newspapers <input type="checkbox"/> alcoholic beverages <input type="checkbox"/> Damp areas <input type="checkbox"/> wool <input type="checkbox"/> beer <input type="checkbox"/> Hay, circus <input type="checkbox"/> road dust <input type="checkbox"/> wine <input type="checkbox"/> Mowing lawns <input type="checkbox"/> chemicals (list) <input type="checkbox"/> cheese, mushrooms <input type="checkbox"/> Dusty environments <input type="checkbox"/> aspirin <input type="checkbox"/> High pollution day <input type="checkbox"/> drugs (list)						
ARE YOUR SYMPTOMS <input type="checkbox"/> Slight <input type="checkbox"/> Moderate <input type="checkbox"/> Severe								
DO YOUR SYMPTOMS INTERFERE WITH YOUR LIFE? <input type="checkbox"/> not at all <input type="checkbox"/> a little <input type="checkbox"/> moderately <input type="checkbox"/> prevent many normal activities								
PATIENT NO.								

