CLARITY
Allergy Center

T. 773-877-3500
4801 W. Peterson Avenue. Suite 306, Chicago, IL 60645
125 New Wilke Road, Suite 100, Arlington Heights, IL 60005

DATE:_____

Name:_____ **Date of birth:**_____

Referred by:_____

Primary symptoms/ reason for referral:_____

_____

What type of pets (if any) do you have in the home?

_____

Have you had any of the following tests performed?
-Please include approximate date, ordering physician, and location of testing if known.

- **Pulmonary function testing (breathing test):** _____

  _____

- **Radiology tests (Chest x-ray, CAT scans, GI studies, MRI's, etc):**

  _____

  _____

- **Allergy skin/ blood tests:**_____
- **Sleep study**:_____
  - If you have a history of sleep apnea, are you using a CPAP machine? Yes No
- **Other**:_____

Please include the name of the physicians you received treatment from and approximate date of most recent visit **(only include if relevant to visit):**

- Primary care doctor_____
- Allergist_____
- Ear/Nose/Throat Doctor (ENT):_____
- Pulmonologist_____
- Other_____

Do you have a <u>FAMILY HISTORY(immediate family only)</u> of:

- **Hayfever:** Yes No

- **Asthma:** Yes No
- **Migraine** Yes No
- **Heart disease** Yes No

Does the patient have a personal history of the following medical conditions?

- **Heart disease:**
  - High blood pressure: Yes No
  - Coronary artery disease (blockage of heart vessels): Yes No
  - Arrhythmias/ palpitations: Yes No
- **Diabetes:** Yes No
- **Acid reflux (GERD):** Yes No
- **Sleep apnea:** Yes No
- **Pneumonia:** Yes No
- **Asthma:** Yes No
- **Food allergies:** Yes No
  Details_____
- **Migraines:** Yes No
- **Emphysema/ COPD:** Yes No
- **Other:**_____

Please list any previous hospitalizations or surgeries:_____

_____

Tonsillectomy/ Adenoidectomy (for child): Yes No
Doctor/Date:_____

Sinus surgery: Yes No
Doctor/Date_____

Smoking History

Do you currently smoke: Yes No
If you have previously smoked, when did you quit? _____

***Are you currently taking a blood pressure medication called a Beta Blocker?** Yes No

MEDICATION ALLERGIES: (include description of reaction)

MEDICATIONS: Please list any medications (including dosage) you take. Please include over the counter medications and herbal supplements:

Symptoms: Please circle all that apply

GENERAL: • Fatigue • Anxiety • Depression • Sleepiness • Weight loss/ gain

EAR: • Pain • Itching •Discharge •Pressure •Popping
• Recurrent ear infections • Decreased hearing

NOSE: • Nasal congestion/ stuffiness • Runny nose •Sneezing • Itching
• Post-nasal drainage • Frequent yellow/green discharge • Frequent Snoring
• Decreased sense of smell • Frequent mouth breathing

MOUTH: • Sore throat • Recurrent throat infections • Other_____

NECK: • Swollen/ tender glands

LUNGS: • Coughing • Shortness-of-breath (SOB) • SOB with exercise
• Chest tightness • Wheezing

HEART: • Chest pain • Palpitations/ heart racing • Lower extremity swelling

STOMACH • Abdominal pain • Diarrhea • Constipation • Bloating
• Heart burn • Coughing/throat clearing after eating
• Food getting stuck in throat when swallowing

SKIN: • Hives/welts • Eczema • Rash • Itching •Dry skin
• Other:_____

MUSCULO-SKELETAL • Joint pain • Muscle aches

HEADACHES: • Sinus pressure/ pain

Disabling headaches: Yes No. If yes, how often_____

How often are you taking headache medications?_____

SLEEP HISTORY:

Adult patients:

Do you feel well rested:

• Always • Most of the time •Some times • Rarely

Have you ever been told you stop breathing at night?: Yes No

How many hours do you typically sleep each night? _____

Do you have trouble falling asleep: Yes No

Do you wake up frequently at night Yes No

Do you snore:

• Always • Most of the time • Sometimes • Rarely • When sick

Pediatric patients;

Snore

• Always • Most of the time • Sometimes • Rarely • When sick

Breath through his/her mouth:

• Always • Most of the time • Sometimes • Rarely • When sick

Sleep restlessly:

• Always • Most of the time • Sometimes • Rarely • When sick

Feel tired during the day

• Always • Most of the time • Sometimes • Rarely • When sick

Sleep in unusual positions (head propped up, hanging over the bed, etc)

Yes No Explain_____

Wet his/her bed excessively (for age): Yes No

Have difficulty concentrating at school or at home

• Always • Most of the time • Sometimes • Rarely • When sick

Take frequent naps

• Always • Most of the time • Sometimes • Rarely • When sick

Suffer from mood changes/ irritability

• Always • Most of the time • Sometimes • Rarely • When sick

Stop breathing for short periods at night

• Always • Most of the time • Sometimes • Rarely • When sick

Have parents who snore loudly?

• Always • Most of the time • Sometimes • Rarely • When sick