

**Wendy L. Smith**

Otolaryngology/Head & Neck Surgery  
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NAME: \_\_\_\_\_  
DATE: \_\_\_\_\_  
HOME#: \_\_\_\_\_ WORK#: \_\_\_\_\_  
CELL#: \_\_\_\_\_  
AGE: \_\_\_\_\_ AGE AT WHICH SYMPTOMS BEGAN: \_\_\_\_\_

**SYMPTOMS:** (Indicate from the list below)

- |   |   |  |  |   |
|---|---|--|--|---|
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Nasal congestion         | <input type="checkbox"/> Red/watery eyes | <input type="checkbox"/> Headaches/migraines         | <input type="checkbox"/> Nausea             |
| <input type="checkbox"/> Colds          | <input type="checkbox"/> Wheezing                 | <input type="checkbox"/> Itchy mouth     | <input type="checkbox"/> Fever                       | <input type="checkbox"/> Indigestion        |
| <input type="checkbox"/> Sneezing       | <input type="checkbox"/> Hoarseness               | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Fatigue                     | <input type="checkbox"/> Diarrhea           |
| <input type="checkbox"/> Runny nose     | <input type="checkbox"/> Scratchy throat          | <input type="checkbox"/> Ears popping    | <input type="checkbox"/> Rashes/hives                | <input type="checkbox"/> Abdominal pain/gas |
| <input type="checkbox"/> Postnasal drip | <input type="checkbox"/> Frequent throat clearing | <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Sensation of lump in throat | <input type="checkbox"/> Eczema             |

**FREQUENCY/TIME OF SYMPTOMS:** (Check corresponding boxes below)

- \_\_\_\_\_ Sporadic (at various times of year but with no pattern)  
 \_\_\_\_\_ Persistent (throughout the year)  
 \_\_\_\_\_ Seasonal (indicate the prominent months below)

- |                               |                              |                                |                                |                              |                               |
|-------------------------------|------------------------------|--------------------------------|--------------------------------|------------------------------|-------------------------------|
| <input type="checkbox"/> Jan  | <input type="checkbox"/> Feb | <input type="checkbox"/> March | <input type="checkbox"/> April | <input type="checkbox"/> May | <input type="checkbox"/> June |
| <input type="checkbox"/> July | <input type="checkbox"/> Aug | <input type="checkbox"/> Sept  | <input type="checkbox"/> Oct   | <input type="checkbox"/> Nov | <input type="checkbox"/> Dec  |

**SURROUNDINGS:** (Indicate where/when symptoms occur)

- |   |   |                                     |  |  |
|---|---|-------------------------------------|--|--|
| <input type="checkbox"/> After mowing     | <input type="checkbox"/> By burning leaves    | <input type="checkbox"/> At school  | <input type="checkbox"/> Animals         | <input type="checkbox"/> Change of seasons |
| <input type="checkbox"/> In damp areas    | <input type="checkbox"/> Near farms           | <input type="checkbox"/> At work    | <input type="checkbox"/> Spring          |  |
| <input type="checkbox"/> While driving    | <input type="checkbox"/> Sitting on furniture | <input type="checkbox"/> In bedroom | <input type="checkbox"/> Fall            |  |
| <input type="checkbox"/> Out walking      | <input type="checkbox"/> Reading a book       | <input type="checkbox"/> In kitchen | <input type="checkbox"/> Hot weather     |  |
| <input type="checkbox"/> While exercising | <input type="checkbox"/> In basement          | <input type="checkbox"/> In attic   | <input type="checkbox"/> Weather changes |  |

**ARE YOU FREQUENTLY EXPOSED TO:**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Indoor pets    | <input type="checkbox"/> Books/papers      | Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No                  |
| <input type="checkbox"/> Plants/flowers | <input type="checkbox"/> Stuffed furniture | Are you around 2nd hand smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No |
| <input type="checkbox"/> Basements      | <input type="checkbox"/> Chemicals         | Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No          |
| <input type="checkbox"/> Attics         | <input type="checkbox"/> Farms/Crop fields | If Yes, number of drinks per week? _____  |
| <input type="checkbox"/> Dust           |  |   |

**LIST TYPE OF:**

Home \_\_\_\_\_ (single family, apt/condo, mobile home)  
 Heating system \_\_\_\_\_ (central, gas, electric, etc)  
 Floor coverings \_\_\_\_\_ (carpet, wood, linoleum, etc.)  
 Pillows \_\_\_\_\_ (foam, feather, cotton)  
 Mattress \_\_\_\_\_ (cotton, feather, foam rubber, waterbed)

**PETS:** (Indicate animals you are frequently exposed to)

- |                              |                                 |                                  |                                      |
|------------------------------|---------------------------------|----------------------------------|--------------------------------------|
| <input type="checkbox"/> Dog | <input type="checkbox"/> Rabbit | <input type="checkbox"/> Bird    | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Cat | <input type="checkbox"/> Horse  | <input type="checkbox"/> Hamster |                                      |

**PREVIOUS ALLERGY TESTING:**

Have you ever been tested for allergies?  Yes  No

If Yes:

When: \_\_\_\_\_

Method:

Skin Test

Where: \_\_\_\_\_

Blood Test

If allergy testing has been done please list below the name of the doctor, clinic, and city where you were tested.

\_\_\_\_\_

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**FAMILY HISTORY:** (Indicate members of your family who have been tested for allergies and are positive)

Mother

Sister

Grandmother

Father

Brother

Grandfather

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**MEDICAL HISTORY:** (Check if you now have or have ever been diagnosed with)

Diabetes

HIV/AIDS

Bronchitis

Heart Trouble

Chronic lung disease

Thyroid problems

High Blood Pressure

Asthma

Severe allergic reaction

Stroke

Depression

Psychiatric disorders

Bleeding Disorders

Cancer

Sleeping disorders

Kidney or Liver problems

Seizure disorder

Other: \_\_\_\_\_

Arthritis

Migraines

\_\_\_\_\_

**\*Women:** Are you pregnant now or think you may be?  Yes  No

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**LIST ALL MEDICATIONS THAT YOU CURRENTLY TAKE:**

(Including **over-the-counter** and **herbal** supplements)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**ARE THERE ANY REACTIONS OR PROBLEMS YOU NOTICE WITH ANY PARTICULAR FOODS?**

If so, please list the food(s) and reaction(s) below.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
(Patient or Guardian Signature)

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