NAME: ______________________________ D.O.B. _______________ DATE: _____________

ALLERGY AND ASTHMA CENTER OF SOUTHWEST ARLINGTON

Please circle symptoms that apply.

NOSE

Runny	Blocked
Stuffy	Sneezing
Loss of smell	Itchy

EYES

Watery	Itchy
Puffy lids	Red
Dark circles	

EARS

Popping	Blocked
Hearing loss	Itchy
Frequent Infection	

THROAT

Sore	Itchy
Drainage	

CHEST

Wheeze	Cough
Phlegm	Pain
Tightness	
Shortness of breath	

OTHERS

Skin rash	Nausea
Headache	Fatigue
Abdominal pain	

WORST SEASON

Spring	Summer
Fall	Winter
All year	

CURRENT MEDICATIONS

DRUG ALLERGIES

PETS AT YOUR HOME

Cat	Horse
Other_________	Dog

ANY ALLERGY OR ASTHMA IN YOUR FAMILY? **Y** **N**

WHO?

Father Mother Sibling Children

Are immunizations current? **Y** **N**