# BEST LASER THERAPY™
# ALLERGY QUESTIONNAIRE

**PATIENT INFORMATION** Today's Date: _____ Date of Birth_____
Name: _____
Address_____ City_____ State_____Zip_____
Home Phone: _____ Work Phone _____ Cell /Pager: _____ Age _____
Email address _____
Mother's Name if minor_____Father's Name if minor_____
Name of Individual to contact in case of emergency: _____Phone : _____
Number of Children: ____ Names and ages of children: _____
**ARE YOU PREGNANT?** □NO □YES
Your Occupation: _____ Your Employer _____

Referred to this office by: □TV □Screening Where? _____
□Seize the deal □Internet search □Newspaper □Letter □Health Journal □Post Card □Radio □Flyer □Phone Call
□Friend – Name? _____ □MD – Name? _____ □Other_____

Payment is due at the time of service.

Signature: _____ Date: _____

**Although your history and symptoms are very important in our analysis of your condition, it is also important for us that you understand:**

- *An Allergy is NOT a disease. It is nothing more than your body reacting inappropriately to what should be a harmless substance, consequently activating the body's natural defense mechanism in the form of symptoms.*
- *A symptom is an attempt by your body to tell you that something is wrong.*
- *We will be treating the cause of your allergy.*
- *We do not use medications in this program.*
- *Our procedures are safe, painless and effective for people of all ages.*

**My main problem is:**_____

**THESE PROBLEMS ARE:** □ RAPIDLY IMPROVING □ SLOWLY IMPROVING □ GRADUALLY WORSENING
□ FLUCTUATES BUT GETTING BETTER □ REMAINS THE SAME □ RAPIDLY WORSENING

**SYMPTOMS ARE WORSE IN THE:** □ Morning □ Afternoon □ Evening

**SYMPTOMS/COMPLAINTS:** □COME & GO □ARE CONSTANT
**SYMPTOMS INTERFERE WITH**: sleep___. exercise/activity ___. school(missed days)___. work(missed days)___

**AGE WHEN SYMPTOMS STARTED**
□ Infant (Age 0-3) □ Adolescent (Age 13-18) □ Adult (Age 26-40)
□ Child (Age 4-12) □ Adult (Age 19-25) □ Adult (Age 41+)
**How Many times per week do you notice the symptoms?**_____
**On Average How bad are the symptoms on a scale of 1 – 10?**_____

**Personal History:**
1. Allergies to **Medication** (list medication & type of reaction):
_____
2. Allergies to **Food** (list food & type of reaction):
_____
3. Allergies to **Bees**_____ Allergies to **Latex**_____ Allergies to **Penicillin**_____
4. Have you ever had an **anaphylactic attack** due to an allergy? _____ Not Sure___

Do you have or carry an Epi-pen with you? _____ (Epinephrine for a severe allergy attack)
5. Have you ever **been hospitalized due to an allergy attack**? _____ What was the Allergy?_____
6. Allergies to Pets (list all animals and type of reaction)

_____

7. Environmental Allergies-grass, pollen, dust ( list all and type of reaction)

_____

8. Are your allergies **worse in certain months** of the year? Which?_____

9. All **medications** presently being taken and reason (include anti-inflammatory medicines such as Motrin, Aleve, Aspirin, and allergy or asthma medications such as pills, nasal sprays, inhalers, herbs and any vitamins

_____

_____

_____

10. Are you currently receiving **allergy shots**?_____ Do they help?_____
11. Consultation by doctors within the past year (name of doctor & reason):

_____

**Family History: (Asthma, Allergies, Eczema, Sinus Infection)**

| Family Member | Condition |
|---|---|
| _____ | _____ |
| _____ | _____ |

**Have you ever been diagnosed with any of the following conditions?**
Fibromyalgia___ Psoriasis___ Eczema___ Chronic Sinusitis___ Irritable Bowell Syndrome___ Asthma__
Acid Reflux___ Migraine Headaches___ Autism___ ADD/ADHD___ Allergies to Digestive Hormones__

**Allergy History and General Review of systems** (check any signs or symptoms that your allergies cause):
cough ____ itchy eyes ____ frequent bronchitis____ shortness of breath ____ red eyes ____fatigue___
frequent sinusitis____ wheezing or chest tightness ____ watery eyes ____ wheezing/rash with aspirin___
nasal congestion ____ discharge from eyes ___ runny nose ____ ear infections____ sneezing ___
itchy, full, or popping of ears ____ change in weight____ nose bleeds ____ hearing loss ___ snoring___
change in bowel habits____ difficulty smelling odors ____ pain in temples ____ blood in urine___
itchy nose ____ pain in cheeks ____ feeling depressed____ nasal polyps ____ pain in forehead___
headache ____ itchy skin ____ joint pain____ swelling of lips or tongue___ hives____ rashes ____
frequent colds ___ sinus pain ___ recurrent ear infections __ decreased smell___
nasal or sinus surgery ___

**F. Mark With a W if any of these factors make your allergies worse.**
Early in Morning___ Daytime__ Night__ Indoors__ Outdoors___ A/C___ Dust___ Mildew___ Odors___
Leaves__ Menstrual Cycle__ Pregnancy__ Hobbies__ Smoke__ Cold__ Work__ Stress___ Cut Grass___
Weather change___ Odors/Fragrance___

**Check the following factors that apply.**
***I live in a/an:*** ____ house _____ # of years OR _____ apartment _____ # of years
***I smoke/smoked*** ____# cigs/day for ____# of years stopped smoking ____# of years ago (approx.)
***My home has:***

| | | |
|---|---|---|
| ____ cats (how many) ____ | ____other pets (list) _____ | |
| ____ dogs (how many) ____ | ____ radiant heat | ____forced air heat with vents |
| ____feather pillows | ____ central (a/c) | ____window unit a/c |
| ____washable pillows | ____ plants in house | |
| ____wall-to-wall carpeting in bedroom | | ____stuffed animals in bedroom |

# PATIENT HISTORY REVIEW OF SYSTEMS

**CHECK ALL THAT APPLY (PAST or PRESENT)**

| GENERAL | MUSCULOSKELETAL | NEUROLOGICAL |
|---|---|---|
| Recent weight gain | Arthritis | Lightheaded/Dizzy |
| Recent weight loss | Rheumatoid Arthritis | Memory loss |
| Fatigue | Broken Bones | Headaches |
| Fever | Osteoporosis | Migraines |
| Allergies | Gout | Numbness |
| Loss of appetite | Scoliosis | Weakness |
| Chills | Spinal Trauma | Stroke |
| Cancer of Any Kind | Joint Pain (anywhere) | Tingling/Numbness |

| CARDIOVASCULAR | RESPIRATORY | INTERGUMENTARY (SKIN) |
|---|---|---|
| Heart Attack | Coughing | Bruise Easily |
| Swelling of Ankles | Coughing Up Blood | Skin Rashes |
| High Blood Pressure | Chronic Cough | Discoloration |
| Low Blood Pressure | Chest Pain | Psoriasis |
| Shortness of Breath | Asthma | Changes in Moles |
| Pain Down Left Arm | Pneumonia | Sores |
| Profuse Sweating | Bronchitis | Scars |
| High Cholesterol | Tuberculosis | Itching |

| EYES, EARS, NOSE & THROAT | GASTROINTESTINAL | GENITOURINARY |
|---|---|---|
| Blurred Vision | Gall Bladder Problems | Painful Urination |
| Double Vision | Liver Problems | Blood in Urine |
| Ear pain | Pain over Stomach | Frequent Urination |
| Hoarseness | Ulcers | Kidney Infection |
| Nose Bleeds | Colitis | Kidney Stones |
| Glaucoma | Hiatal Hernia | Incontinence |
| Dental problems | Blood in Stool | |

Other/Explanations:

_____

_____

_____

**Clinician/Staff Signature** _____ _____