



F. Do any of the factors below make your symptoms worse (W), better (B), or do not bother you at all (-).

	Nose	Eyes	Wheeze/ Cough	Skin		Nose	Eyes	Wheeze/ Cough	Skin
Early in Morning					Menstrual Cycle				
Daytime					Pregnancy				
Night					Hobbies				
Indoors					Smoke				
Outdoors					Colds				
A/C					Work				
Dust					Stress				
Mildew					Cut Grass				
Odors					Leaves				

G. Check the following factors that apply to you and also put a "W" next to those that make your symptoms worse

*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) \_\_\_\_ breed (list) \_\_\_\_\_  
 \_\_\_\_ 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

H. Family History: Check symptoms or disease each family member has or had.

	Self	Mother	Father	Sister #	Brothers #	Grandparents (Mother's)	Grandparents (Father's)	Daughters #	Sons	Aunts	Uncle
Asthma											
Allergies											
Skin problems											
Hives, lip / tongue swelling											

I. List any of above family who has or had the following health problems.

High Blood Pressure \_\_\_\_\_ Diabetes (sugar problems) \_\_\_\_\_  
 Heart Disease \_\_\_\_\_ Kidney or Lung Problems \_\_\_\_\_  
 Cancer \_\_\_\_\_ Thyroid Disease \_\_\_\_\_  
 Irregular heartbeat \_\_\_\_\_ High Cholesterol \_\_\_\_\_

J. Past surgeries you have had (please list with approximate dates).

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

K. List additional health problems or anything else you believe doctors should know about you.

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