PATIENT'S NAME _____ DATE _____

ROS: Please CIRCLE ONLY THOSE SYMPTOMS that you are experiencing with your CURRENT PROBLEM:

- CONST: None, Weight Loss / Gain, dizziness, tired
- SKIN: None, Eczema, hives, contact rash, itching, hair loss, nail changes
- EYES: None, Watery, red, itchy, swollen, rash, rubbing
- E Ears: None, Decreased hearing, stopped up, frequent earaches, itchy, ringing
- N Nose: None, Stuffy, itchy, runny, sneezing, "sniffing & snorting", frequent nose bleeds, mouth breathing, polyps, frequent colds, snoring, nose rubbing
- T Mouth: None, Ulcers, gum problems, cold sores
- Throat: None, Drainage down throat, scratchy, itchy, frequent throat infections, hoarseness, clucking, clearing throat often
- Sinus: None, Sinus infections, sinus headaches, yellow-green nasal drainage
- RESP: None, Croupy/barky cough, wheezing, bouts of bronchitis, shortness of breath, problems with exertion
- CARDVASC: None, Shortness of breath, chest pain
- GI: None, Stomach aches, vomiting, diarrhea, nausea, gas N3:2
- GU: None, Bladder/kidney infection, kidney stone, prostate problem
- MUSC: None, Muscle soreness, joint problems
- NEURO None, Headaches, seizures N4:8
- PSYCH: None, Depression, bipolar disorder

- **PAST HISTORY**:

Have you ever been skin tested and/or placed on allergy injections? Yes No
If yes, how long did you take allergy injections? From _____ To _____ Where _____
All past severe illnesses: _____
Do you have: High Blood Pressure, Diabetes, Glaucoma, Prostate Problems, Cancer, Migraines, Heart disorder, Thyroid
Other significant health problems: _____
Surgical Procedures: _____
Any non-surgical hospitalizations: _____
Have you lived in a household with anyone who had: Hepatitis _____ AIDS _____ Tuberculosis _____
If under 2 years, were you: Term Premature Any respiratory problems at birth: _____
If under 2 years, were you: Breastfed Bottlefed Any problem taking milk: _____

- **FAMILY HISTORY**: Please specify which family member other than you in your family has (state relationship):

Asthma _____ Immune Problem _____ Food Allergy _____
Hay Fever _____ Migraine Headaches _____ Cystic Fibrosis _____
Eczema _____ Hives/Swelling _____ Drug Allergy _____

- **ENVIROMENTAL HISTORY**

RESIDENCE: House Apartment Mobile Home Duplex Townhouse Age of Residence _____ N3:1
LOCATION: Town Country Suburbs EXTERIOR: Sunny Shady N4:3
INSIDE HOUSE PETS INCLUDE: _____
Is there anyone who lives in your home who smokes? Yes No Who? _____
DO YOU SMOKE? Yes No If yes, number of packs/day _____ Number of years you have smoked _____
Did you smoke in the past but have now quit? Yes No If yes, when did you quit? _____
HEATING SYSTEM: Central (gas or electric) Space Heaters Kerosene Heaters Wood Burning
AIR CONDITIONING: Central Window Unit FANS: Ceiling Fan in Bedroom Attic Fan WINDOWS: Open/Closed
PATIENT'S BEDROOM: Own room or Shares bedroom with _____
PATIENT'S PILLOW: Feathers Polyester Foam Rubber PATIENT'S BLANKET: Cotton Wool Synthetic
PATIENT'S BEDSPREAD: Washable Dry Clean Only None
FLOOR COVERING IN PATIENT'S ROOM: Carpet Wood Floor Tile Floor Area Rugs
SEASONAL PATTERN: Worse in Spring, Summer, Fall, Winter; Year-round
SYMPTONS INCREASED BY: _____

- **SOCIAL HISTORY**: Please CIRCLE AND/OR COMPLETE the appropriate answers:

MARITAL STATUS: Single Married Widowed Divorced, # of People in Household___ Lives with: _____
PLACE OF EMPLOYMENT (Adult) _____
NAME OF DAY CARE / SCHOOL (Child) _____ Grade _____