

Form to be completed by patient:

COAST ALLERGY/ASTHMA CENTER

Patient Name: _____ **Date:** _____ **Chart #** _____

Please circle any of the following symptoms which you are **currently** experiencing, or that have caused you **serious** problems in the past.

General: Fever, weight loss, weight gain, night sweats, severe itching, loss of appetite, fatigue, cold intolerance, heat intolerance

Eye/Ear/Nose & Throat: Loss of vision, blurry vision, cataracts, glaucoma, loss of hearing, loss of taste, loss of smell, excessive tearing, dry eyes, itchy eyes, conjunctivitis, ear infections, ringing in ears, loss of balance, post nasal drip

Lymph glands: Glandular swelling, glandular tenderness

Respiratory: Shortness of breath, wheezing, chronic cough, night time awakening, chest tightness, mucous production, pneumonia, pleurisy, sleeps sitting up to breathe easier

Heart: Chest pain, palpitations, swelling of ankles, inability to lie flat in bed

Intestinal tract: Nausea, vomiting, heartburn, indigestion, trouble swallowing liquids or food, abdominal pain, constipation, diarrhea, excessive gas, food intolerances, gallstones, acid or sour taste in mouth, blood in stool

Reproductive: Irregular periods, skipped periods, unusual vaginal bleeding, menopause, infertility, miscarriages, pregnancy

Urinary: Kidney stones, inability to urinate, prostate problems, kidney infections, urinary tract infections

Skeletal/Muscle: Early morning joint stiffness, joint swelling, joint pain, gout, low back pain, osteoporosis, fractured bones, muscle pain

Skin: Skin rash, hives, eczema, skin tumors, growths, excessive hair loss, psoriasis

Neurologic: Fainting spells, severe headaches, epilepsy/seizures, difficulty with memory, inability to concentrate

Psychiatric: Depression, anxiety, panic attacks, phobias, excessive worry