ALLERGY SCREENING

Up to 95% of those living in the US would benefit from knowing what they are allergic to so they could avoid the health problems allergies cause. Please place a checkmark at each of your symptoms and return the completed checklist to your physician. Be sure to include symptoms that you've 'learned to live with'.

Digestive Tract
- Belching
- Bloated Feeling
- Constipation
- Diarrhea
- Nausea
- Passing Gas
- Stomach Pains
- Vomiting

Head
- Dizziness
- Faintness
- Headaches
- Insomnia
- Lightheadedness

Ears
- Drainage from Ear
- Ear Aches
- Ear Infections
- Hearing Loss
- Itchy Ears
- Ringing in Ears

Emotions
- Aggressiveness
- Anxiety/Fear
- Depression
- Irritability/Anger
- Mood Swings
- Nervousness

Energy & Activity
- Apathy
- Fatigue
- Hyperactivity
- Lethargy
- Restlessness
- Sluggishness

Skin
- Acne
- Dermatitis
- Eczema
- Excessive Sweating
- Flushing/Hot Flashes
- Hair Loss
- Hives/Rashes
- Itching

Weight
- Binge Eating
- Compulsive Eating
- Cravings
- Excessive Weight
- Underweight
- Water Retention

Other
- Anaphylactic Reactions
- Chest Pains
- Frequent Illness
- Genital itch
- Irregular Heartbeat
- Rapid Heartbeat
- Urgent Urination

Mouth & Throat
- Canker Sores
- Chronic Cough
- Gagging

Joint & Muscles
- Aches in Muscles
- Arthritis
- Feeling of Weakness
- Limited Movement
- Pain in Joints
- Stiffness

Lungs
- Asthma/Bronchitis
- Chest Congestion
- Difficulty Breathing
- Shortness of Breath
- Wheezing

Mind
- Confusion
- Poor concentration
- Poor Memory
- Stuttering/Stammering

Phone #: ____________________________
During the last 30 days, have the symptoms you noted on the previous page...

1. Prevented you from getting a good night’s sleep? □ Yes □ No
   If yes, which symptoms? ____________________________________________ How many nights? ________

2. Affected your performance at your place of employment? □ Yes □ No
   If yes, which symptoms? ____________________________________________ How many days? ________

3. Caused you to call in sick to your place of employment? □ Yes □ No
   If yes, which symptoms? ____________________________________________ How many days? ________

4. Caused you to leave your place of employment early? □ Yes □ No
   If yes, which symptoms? ____________________________________________ How many days? ________

Do you or anyone in your family have a history of allergies? □ Yes □ No

Have you or has anyone in your family ever been to an allergist or been tested for allergies? □ Yes □ No

Do you have allergic reactions within 90 minutes or sooner after exposure to particular topical, ingested, or inhaled substances such as:

□ Animal Danders □ Iodine □ Plants or trees
□ Cosmetics □ Latex □ Shampoos and soaps
□ Dust, pollen, or mold □ Laundry Detergent □ Sulfur
□ Foods □ Medicines
□ Insect Stings □ Penicillin

If so, can you identify the particular offending substance?

Do you have severe, dramatic allergic reactions (anaphylaxis) with skin reactions, swelling, respiratory distress, and/or low blood pressure?

If so, what causes it? (eg. Bee stings, penicillin, etc.)