6114 Sherry Lane
Dallas, TX 75225

Barbara S. Baxter, M.D.

Board Certified in Internal Medicine
and Allergy - Immunology

214.363.8653

Patient's Name:_____ Age:_____ Today's Date_____

Check your main symptoms:

_ Sneezing
_ runny nose
_ stuffy nose
_ post nasal-drainage
_ sinus infections
_ blocked or infected ears
_ headache
_ itchy, watery eyes
_ asthma
_ cough
_ chest infections
_ stomach or intestinal distress
_ sore throats
_ hoarseness
_ skin rashes
_ eczema
_ itchy skin
_ hives

How long have you been having these symptoms? _____
Are they worse at certain times of the year? _____ at different times of the day?_____
Are they worse of better when you travel elsewhere? _____
What are you currently taking for your symptoms? _____
What medicines have you taken that did *not* help or had side effects?_____

How much school or work have you missed this year due to this problem?_____
Do you have a family history of allergies? (*If yes, who and what type?)*_____

Home Environment Check the boxes that describe your home.

_ dogs
_ cats
_ other pets
_ carpeted
_ central heat/air
_ new home
_ older home
_ ceiling fans
_ venetian blinds
_ lots of house plants
_ lots of books
_ lots of magazines
_ some damp areas
_ fluffy comforters/blankets
_ someone smokes
_ my bathroom is attached to my bedroom

Work or School Environment:

_ office building
_ outdoors
_ retail
_ factory

If you work outside the home, check the boxes that describe your work.

_ good ventilation system
_ older ventilation system
_ fans are used a lot
_ people smoke a lot
_ I feel better at work
_ I feel worse at work
_ solvents/odors at work
_ it is dusty at work

Do you seem to react to foods? (Which ones?)_____
Do weather changes bother you?_____
Do irritants (perfumes, cigarette smoke, hairspray, paint, etc,) aggravate your symptoms?_____
Are you allergic to drugs or insect stings? (Describe reactions.)_____

_ I have had skin tests before. _ I have taken shots before. The shots helped a lot / a little / not at all (circle one).

List all medication you take on a regular basis:.

_____
_____

Do you smoke?_____
Do you have high blood pressure?_____
Do you have heart trouble?_____
Do you have diabetes?_____

List any hospitalizations you have had

Age or Year Reason for Hospitalization

List places you have lived: Ages or Years