Patient Intake Form

CENTRAL ALLERGY AND ASTHMA CLINIC **DR.PRIYANKA LALL**
203-157 Queen Street E

NAME________________________________ DOB____________________________

Q1.Your doctor has referred you for allergy assessment. Please list your main symptom in detail.

Q2. Do you have the following nasal symptoms? Sneezing, stuffy nose, runny nose, itchy nose, post nasal drip, any seasonal changes.

Q3,Are you prone to sinus infections? Colour of nasal discharge and colour of post nasal drip. Any CT scan or previous sinus surgery or nasal polys, any loss of sense of smell?

Q4.Any history of eczema, asthma or food allergy or drug allergy?

Q5. Have you had allergy testing before? If Yes, what were the results?

Q6. Past medical history: Any surgery or medical issues such as diabetes, heart disease, blood pressure or others?

Q7. Please list all of your current medications including herbal medications.

Q9.What is your Occupation? Any smoking history? How many years and how many cigarettes per day.

Q10. Home Environment: Do you live in a house/apartment/townhouse? How old is it? Do you have carpeting or hardwood flooring? Any pets?

Q11.Family history. Please list close family members who have asthma, nasal allergies, eczema, sinus problems.