

◇ **THE NEXT QUESTIONS ARE
DESIGNED TO HELP
CHARACTERIZE YOUR SYMPTOMS**

Are your symptoms increasing or decreasing in severity and frequency? Circle correct answer please:

Increasing Unchanged Decreasing

Does your illness wake you during the night.

Please Circle Yes No

Do you wake up feeling ill in the morning?

Please Circle Yes No

Does your illness make you feel sleepy during waking hours? Please Circle Yes No

**DO YOUR SYMPTOMS OCCUR AROUND:
PLEASE CHECK:**

- ◇ OLD LEAVES
- ◇ OLD BOOKS
- ◇ LAWN MOWING
- ◇ ANIMALS Which _____
- ◇ OLD BARNs
- ◇ HAY
- ◇ DAMP BASEMENT
- ◇ OTHER _____

**ARE YOUR SYMPTOMS PRODUCED OR
AGGRAVATED BY ANY OF THE
FOLLOWING:**

- ◇ ALCOHOL
- ◇ PERFUMES
- ◇ INSECTICIDES
- ◇ HAIR SPRAY
- ◇ AUTO FUMES
- ◇ STRONG ODORS
- ◇ CHEMICAL ODORS
- ◇ PAINT FUMES
- ◇ WEATHER CHANGES
- ◇ HOT FOOD
- ◇ COLD FOOD
- ◇ AIR CONDITIONING
- ◇ HIGH POLLUTION DAYS
- ◇ CRYING
- ◇ LAUGHING
- ◇ OTHER _____

**HAVE YOU LIVED FOR MORE THAN
ONE YEAR AWAY FROM THE
NORTHEAST?**

Please circle: Yes No

If yes, where? _____

Did you have an allergic problem while there. If so please list below:

What Problem? _____

Since you have your current allergy problems have you traveled anywhere, where the problem was better. Please list location below

Worse? Please list below:

**HAVE YOU REACTED TO AN INSECT
ESPECIALLY A STINGING INSECT OR
FIRE ANT IN ANY OF THE FOLLOWING:**

- ◇ HIVES
- ◇ SWELLING
- ◇ WHEEZING
- ◇ SHORTNESS OF BREATH
- ◇ SHOCK
- ◇ ANYTHING REQUIRING AN
EMERGENCY ROOM VISIT

**ANY OTHER SYMPTOM OR PROBLEM
PLEASE LIST BELOW:**