ALLERGY HISTORY

Patient Name _____ Date. _____

Patient Number _____ Age _____ M/F

Branson Allergy Symptom Evaluation™ (BASE)

COMPLAINTS:
Please circle the appropriate number 0 to 3 according to severity:
0 = absent (no symptoms evident) **2 = moderate** (tolerable)
1 = mild (symptoms present, but minimal awareness), **3 = severe**

Nasal discharge (runny nose)	0	1	2	3	Headache	0	1	2	3
Nasal obstruction (stuffy nose)	0	1	2	3	Hives	0	1	2	3
Nasal itching	0	1	2	3	Eczema	0	1	2	3
Sneezing	0	1	2	3	Itching ears	0	1	2	3
Watery eyes	0	1	2	3	Sinus or ear infections	0	1	2	3
Itchy eyes	0	1	2	3	Frequent colds or sore throat	0	1	2	3
Gritty feeling (eyes)	0	1	2	3	Sensitivity to pet hair	0	1	2	3
Cough	0	1	2	3	Itchy throat	0	1	2	3
Wheezing	0	1	2	3	Sinus pressure	0	1	2	3
Difficulty breathing	0	1	2	3	Sinus pain	0	1	2	3

Other symptoms causing you problems?
_____

MEDICATIONS:
How often do you take medications for your allergy symptoms?
0 = never 1 = occasionally (several times a month or less) 2 = frequently (several times a week)
3 = daily

Antihistamines	0	1	2	3	Nasal Steroids (Flonase, Nasacort)	0	1	2	3
Oral Steroids	0	1	2	3	Asthma medication (Inhaler, Singulair, Advair)	0	1	2	3
Eye drops	0	1	2	3	Other allergy-related medications _____				

Does any medication give you complete relief of symptoms? _____

GENERAL ALLERGY HISTORY:
How many months of the year do you have allergies? _____ How many years? _____
In what season are they worse (check all that apply): O Spring O Summer O Fall O Winter
Have you been allergy tested before? O Yes O No
If yes, which type: O Skin prick/Puncture O Blood draw
Have you previously received allergy shots? _____Allergy drops?_____ If yes, when? _____
Do you smoke or use tobacco products? _____
List any animals you have in or around the home _____
Who else in your family has allergies? _____

PROVIDER ONLY
RAW SCORE: _____ /25 0-25 = MILD 26-50=SIGNIFICANT
SCORE: _____ (Multiply raw score by 4) 51-100 = SEVERE 100+= VERY SEVERE