

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): Spring Summer Fall Winter

Have you been allergy tested before? Yes No

If yes, which type: Skin prick/Puncture 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