



Mark E. Bubak, M.D. &  
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**605-336-6385**  
*YourAllergyRelief.com*

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Clinic Number: \_\_\_\_\_

What problem brings you to the Doctor? \_\_\_\_\_

\_\_\_\_\_

Were you referred to us? If yes, by whom? \_\_\_\_\_ Primary Physician \_\_\_\_\_

Do you want a report sent to your physician? Yes No

Describe any problems with:

Nose: *(Plugged, itch, sneeze, drainage)*

Eyes: *(Water, Itch)*

Ears:

Sinuses:

Lungs: *(Cough, Wheeze, Shortness of Breath, Tight Chest)*

Skin:

Frequent Infections:

When did your problem start? \_\_\_\_\_

When do you have problems? Spring, Summer, Fall, Winter

What have you found triggers your problem? *(Dust, animals, smells, exercise, etc.)* \_\_\_\_\_

\_\_\_\_\_

What treatments have been tried? *(Avoidance, Over the counter or prescription Medication, Allergy Shots)* \_\_\_\_\_

\_\_\_\_\_

What are you currently using? *(List ALL Medications)* \_\_\_\_\_

\_\_\_\_\_

What tests have been done? *(X-Rays, Allergy Tests, Breathing Tests, Etc.)* \_\_\_\_\_

\_\_\_\_\_



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List your medication allergies. \_\_\_\_\_

List your food allergies. \_\_\_\_\_

Any allergy to wasps, bees, yellow jackets, hornets? \_\_\_\_\_

Do You Smoke? \_\_\_\_\_ Did you ever smoke? \_\_\_\_\_

Does anyone smoke at home? \_\_\_\_\_ Who? \_\_\_\_\_

What types of pets do you have? \_\_\_\_\_

Type of pillows--Feather, Non-feather Type of Heat \_\_\_\_\_

What is your Job? \_\_\_\_\_

What are Your Hobbies? \_\_\_\_\_

**Family History:** Anyone with Hayfever, Asthma, Eczema (Atopic Dermatitis), Immunodeficiency or Cystic Fibrosis? (*List*)

Other:

List past Hospitalizations and Surgeries: \_\_\_\_\_

Do you have other medical problems currently? \_\_\_\_\_

Circle any current or past areas with medical problems:

- |              |                |               |                 |
|--------------|----------------|---------------|-----------------|
| Eyes         | Nose           | Ears          | Skin            |
| Hair         | Throat         | Chest         | Heart           |
| Stomach      | Gall bladder   | Bowels        | Liver/Hepatitis |
| Nerves       | Bladder/kidney | Legs          | Blood Vessels   |
| Thyroid      | Pneumonia      | Asthma        | Hives           |
| Anaphylaxis  | Arthritis      | Immune System | Headache        |
| Hypertension | Depression     | Anxiety       | Cholesterol     |
| Weight Loss  | Fever          | Other _____   |                 |