◊ **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: