ALLERGIC RHINITIS WORKSHEET

EXAMINING FACILITY:	FACILITY UIC:
TODAY'S DATE:	EXAMINER'S PHONE #:
REQUESTING WAIVER?	REQUESTING TO ELIMINATE WAIVER?

HISTORY

SYMPTOMS		FREQUENCY		TREATMENT		PRIOR PROBLEMS	
	RHINORRHEA		SPRING		None		EAR BAROTRAUMA
	CLEAR		SUMMER		OTC Med		SINUS BAROTRAUMA
	CLOUDY		FALL		Steroid Spray		SINUSITIS; CHRONIC? RECURRENT? ACUTE?
	LACRIMATION		WINTER		Rx. Med*	OTHER:	
	SNEEZING		PERENNIAL		AIT**		
	CONGESTION						
	ITCHING						

How many years of sx.?	Typical duration of sx:
CURRENT SYMPTOMS (if no sx. at present, when was pt. last symptomatic?):	
CURRENT THERAPY, IF ANY: *(LIST MEDS)	PAST EFFECTIVE THERAPY:
**IF HX. OF ALLERGY IMMUNOTHERAPY, DATE BEGUN:	DATE COMPLETED:

PHYSICAL EXAMINATION

RIGHT EAR:	VALSALVA?
LEFT EAR:	VALSALVA?
NOSE:	
MOUTH:	
OROPHARYNX:	
SINUS FILMS RESULTS: (Include actual films if abnormal / **submit all films on APT applicants**)	
ENT EVALUATION: **(ONLY IF REQUIRED PER WAIVER GUIDE)**	
ALLERGY EVALUATION**: (ONLY IF REQUIRED PER WAIVER GUIDE)**	
IMPRESSION:	

FLIGHT SURGEON'S RECOMMENDED DISPOSITION

	NPQ, WAIVER RECOMMENDED		PQ, DISCONTINUE WAIVER
	NPQ, WAIVER NOT RECOMMENDED		

FLIGHT SURGEON SIGNATURE/ STAMP	
PATIENT'S SIGNATURE:	DATE:
PT'S NAME: LAST/ FIRST/ MIDDLE/RANK/RATE	
DATE OF BIRTH: AGE:	SSN: