

ALLERGY HISTORY FORM

Patient Name: _____ Age: _____

Referred By: _____ Primary Physician: _____

What is the Major Reason(s) for this Allergy Consultation? _____

Complete the following section if there is a history of
NASAL AND EYE SYMPTOMS

Circle the following if they apply to you.

NONE

Nasal Stuffiness Sneezing Post Nasal Drip Itchy Nose Itchy Eyes

Headache Ear Problems Other: _____

Nasal Discharge: NONE Clear White Yellow Green

When are you symptomatic? Winter Spring Summer Fall Year-Round

When are symptoms the worst? Winter Spring Summer Fall Year-Round

Medications taken and their effects

NONE

Suspected or known causes of these symptoms

Colds Dust Odors/Fumes Cigarette Smoke

Trees Weeds Grass Mold Mowing Lawn

Dogs Cats Latex Foods Other

Number of Sinus Infections treated in the past year: _____ NONE

Last Antibiotics: _____ NONE

Did you have a Sinus X-ray? Yes No Date: _____

Did you have a Sinus Cat Scan? Yes No Date: _____

History of Nasal Polyps? Yes No

Name: _____

Complete the following section if there is a history of
SKIN PROBLEMS

NONE Eczema Hives Rash Other _____

Approximate date symptoms first noted:

Known or suspected causes of the rash:

Did any of the following occur around the time of onset of the rash?

- Foreign Travel Change in medications Extended Farm Visit Change in diet
- Viral infection /cold Change in cosmetics Upper Respiratory Infection Change in detergents
- Diarrheal Illness Course of antibiotics Change in soap, shampoo, etc.
- Change in home/work environment

Complete the following section if there is a history of
ASTHMA, WHEEZING, BRONCHITIS OR COUGH

Date Symptoms First Noted: _____

Description of symptoms:

- Wheezing Cough Shortness of Breath
- Chest Tightness Tightness in throat Other: _____
- Worse at night Worse during the day Problem during the day and night

Frequency of symptoms:

- Less than twice a week
- 3 or more days a week
- Every day
- More than 2 nights a week

Emergency Room Visits: None 1-2 3-5 >5

Hospitalizations for above: None 1-2 3-5 >5

Medications taken and their effects: NONE

Suspected or known causes of these symptoms.

- Colds Cats Dogs Animals Odors/Fumes Cigarette Smoke
- Trees Weeds Mold Grass Mowing Lawn
- Dust Latex Emotions Food Other
- Exercise Outdoor Sports Cold Air Wind Rain Weather Changes

Name: _____

Have you had any **REACTIONS TO BEE/INSECT STINGS?**

NONE Local reaction at sting site Rash Breathing Problems Other _____

Have you had any **PREVIOUS ALLERGY TESTING?**

NONE YES (if yes continue below)

Date: _____ Positive to: _____

Previous Allergy Injections (please circle)? NO YES

Previous Injection Dates: _____ Last Injection: _____

CIRCLE ANY ADDITIONAL PROBLEMS THAT YOU ARE EXPERIENCING

Depression	Fatigue	Visual Changes	Hearing Problems	Throat Problems
Breathing Problems	Chest Pain	Palpitations	High Blood Pressure	High Cholesterol
Heartburn	Bladder Problems	Seizures	Muscle Aches	Joint Pains
Rash	Itching	Bleeding Problems	Hormone Problems	Thyroid Problems

PAST MEDICAL HISTORY

List any **MEDICATIONS** taken in the past week (include aspirin and vitamins): NONE

List all medical conditions: NONE

List all emergency room visits: NONE

List all hospitalizations: NONE

List any surgeries: NONE

List all **REACTIONS** you have had to **FOODS:** NONE

List **REACTIONS** to **MEDICATIONS:** NONE

Name: _____

FAMILY HISTORY

Enter age and check below if family members have symptoms

	CURRENT AGE	ASTHMA	ALLERGIES	SKIN PROBLEMS	OTHER
FATHER	_____				
MOTHER	_____				
BROTHERS	_____				
SISTERS	_____				
CHILDREN	_____				

ENVIRONMENTAL HISTORY

List **ALL SMOKERS** who live in the home _____

List **ALL ANIMALS** in or around the home _____

How long have animals been in or around the home? _____ Pets allowed in bedroom? YES NO

DWELLING TYPE: House Apartment Condo Townhouse Basement Apartment

AGE OF BUILDING: _____ How long have you lived there? _____

HEATING SYSTEM: Forced Hot Air Electric Baseboard Hot Water Baseboard Radiator Wood Burning Stove
Other _____

BASEMENT: NONE Unfinished Finished History of Water Leakage Damp Dry

BEDROOM: Winter bedroom temperature: _____ Allergy covers? YES NO

Type of Pillow: Synthetic Feather

Bedding: Feather Bed Feather Comforter

Description of Bedroom: Neat Cluttered Dusty Stuffed Toys

FLOOR COVERING: Wall to Wall Carpet Area Rug Wood Floor Carpet over Cement

AIR CONDITIONING: NONE Window Central

AIR FILTER: NONE Room Central

OCCUPATIONAL EXPOSURE(s)

Please describe the **TYPE OF WORK OR DAILY ACTIVITY** _____

Office Setting Outdoor Setting Homemaker School (Grade _____)

Are symptoms affected by work or school? _____

Name: _____

SOCIAL HISTORY

Marital Status (patient or parents if minor): S M D W

Children, or siblings if minor _____

Smoking: Current Past Packs per Day _____ How Long _____

Drug/Alcohol Use _____

Please note any other history that you feel the doctor/nurse should know about you. If appropriate, note any stress or emotional problems that might affect your symptoms: