ALLERGY HISTORY FORM

Patient Name: ________________________________ Age: _____ Appointment Date: ______

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 Stuffyess 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
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: ________________________________________  Date: ______________________

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

______________________________________________________________________________
**FAMILY HISTORY**

Enter age and check below if family members have symptoms

<table>
<thead>
<tr>
<th>CURRENT AGE</th>
<th>ASTHMA</th>
<th>ALLERGIES</th>
<th>SKIN PROBLEMS</th>
<th>OTHER</th>
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<tbody>
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**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? ____________________________________________
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: