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.

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

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: ________________________________________  DATE: ________________

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
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

_________________________________________  _______________________________________

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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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</thead>
<tbody>
<tr>
<td>FATHER</td>
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<td>CHILDREN</td>
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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? ____________________________
Name: _________________________________ Date: ________________

SOCIAL HISTORY

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

Children, or siblings if minor _____________________________________________________________

SUBSTANCE USE (please circle below)

Cigarettes:          Never     Past     Current     Packs per Day _______     How many years _______

Vape:                Never     Past     Current     _______________________

Other tobacco:       ___________________________________________________________________

Drugs/Alcohol:       ___________________________________________________________________

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: