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ALLERGY HISTORY FORM

DATE: ____________________________

TO BE COMPLETED BY PATIENT

NAME: ____ AGE: ________
BIRTHDATE: _________ OCCUPATION: ____________________________________
HOBBIES: ____
DESCRIBE THE REASON FOR YOUR VISIT: ___________________________________
____
____
HAVE YOU HAD A PAST ALLERGY WORK UP? __________________ YEAR: ________
DOCTOR: _________________________________ WHERE: ____________________
RESULT: INJECTIONS? _____________ HOW LONG? _________ HELPFUL? _______
SPECIAL DIET? ____
____ SUCCESSFUL? _____________
INSECT ALLERGY? ____
DATE OF INSECT STING: ____
LOCATION OF STING: ____
REACTION (HOW SOON AFTER STING): _______________________________________
TYPE OF TREATMENT FOR PREVIOUS STING REACTIONS: _______________________

SYMPTOMS	None	Mild	Moderate	Miserable
SNEEZING	[ ]	[ ]	[ ]	[ ]
ITCHY EYES	[ ]	[ ]	[ ]	[ ]
ITCHY NOSE	[ ]	[ ]	[ ]	[ ]
ITCHY THROAT	[ ]	[ ]	[ ]	[ ]
STUFFY NOSE	[ ]	[ ]	[ ]	[ ]
RUNNY NOSE	[ ]	[ ]	[ ]	[ ]
COUGH	[ ]	[ ]	[ ]	[ ]
WORSE W/ EXERCISE/ACTIVITY	[ ]	[ ]	[ ]	[ ]
WORSE AT NIGHT	[ ]	[ ]	[ ]	[ ]
WHEEZE IN CHEST	[ ]	[ ]	[ ]	[ ]
EYE IRRITATION	[ ]	[ ]	[ ]	[ ]
POSTNASAL DRIP	[ ]	[ ]	[ ]	[ ]
SORE THROAT	[ ]	[ ]	[ ]	[ ]
MUCUS	[ ]	[ ]	[ ]	[ ]
CLEARING OF THROAT	[ ]	[ ]	[ ]	[ ]
HOARSENESS	[ ]	[ ]	[ ]	[ ]
RASH	[ ]	[ ]	[ ]	[ ]

WHEEZING/COUGHING

Do you wheeze? ____
Do you cough?____
____
____
Color of sputum (cough secretions): ______________________________________
Do you have chest pain? ____

APPETITE: [ ] Good [ ] Fair [ ] Poor

Any weight change in the past 6 months?__________________________________
Describe any food reactions: ____
____
____
____

ALLERGIC PROBLEMS

YES	NO	CHECK ALL ITEMS
		Asthma
		Hospital visit(s) for Asthma
		Any other breathing problems?
		Hay fever (runny, stuffy, itchy nose, sneezing)
		Hives or swelling
		Eczema or other rashes
		Frequent infections
		Food reactions
		Drug reactions
		Insect reactions
		Latex Allergy
		Previous sinus x-rays

PLEASE DO NOT WRITE IN SPACE BELOW

SENSE OF SMELL: _____________________
HEADACHES: _______________________
DISCOLORED NASAL DRAINAGE: ________

EXCESSIVE EXPOSURES (home, work, school, etc.):

[ ] INDOOR DUSTS
[ ] OUTDOOR DUSTS
[ ] FUMES
[ ] DAMPNESS
[ ] MILDEW
[ ] CHEMICALS
[ ] COSMETICS
[ ] TOBACCO SMOKE
[ ] ANIMALS
[ ] INSECTICIDES
[ ] DETERGENTS
[ ] PAINTS
[ ] CHALK
[ ] ODORS
[ ] OTHER: ________________________

ENVIRONMENT

Age of home you live in ________ [ ] House [ ] Apt. [ ] __________
Your home is in the: [ ] City [ ] Country
Cooling at home: [ ] Air Conditioner [ ] Water Cooler
Heating: [ ] Forced Air (gas) [ ] Electric [ ] Wood
Filters changed: [ ] Regularly [ ] Irregularly
Number of beds in bedroom: _________________________
Type of bed(s): [ ] Spring [ ] Waterbed [ ] Other: ____________
How old is your mattress? _______________
Pillows: [ ] Synthetic [ ] Feather
Is there carpeting in bedroom? __________ if so, how old? ____________
How dusty is bedroom? [ ] Not [ ] Somewhat [ ] Very
How cluttered is bedroom? [ ] Not [ ] Somewhat [ ] Very

BIRTH HISTORY

City, State: _____________________________ Birth weight: ___________
Significant illnesses the first year of life _____________________________

PAST MEDICAL HISTORY

SURGERY ______________________________
____
____
____

DRUG ALLERGIES ______________________________
____
____
____

MEDICATIONS ______________________________
____
____
____
____
____
____
____
____
____
____
____

CAUSES (check those appearing suspicious)

[ ] HOUSE DUST
[ ] TREES
[ ] WEEDS
[ ] GRASSES
[ ] FLOWERS
[ ] MOLDS
[ ] ANIMALS
[ ] UPSET FEELINGS
[ ] FOODS
[ ] COSMETICS
[ ] GARAGE
[ ] OPEN FIELDS
[ ] ALCOHOL
[ ] ODORS
[ ] SUN
[ ] DAMPNESS
[ ] DRYNESS
[ ] TOBACCO
[ ] CLOTHING
[ ] FARMS
[ ] WEATHER CHANGE
[ ] TEMPERATURE CHANGE
[ ] OTHER
[ ] HEAT
[ ] COLD
[ ] WIND
[ ] ASPIRIN
[ ] SULPHITES
[ ] MSG

EXPOSURE TO ANIMALS (home and away)

Types of animals: ____
How much indoor contact? ______________________ Outdoor contact? ___________

TOBACCO/ALCOHOL

Number of years smoked: _______ Average pack/day: ________ Date stopped: _______
Do you have smokers cough? ____________ Does anyone in the family smoke? _______
Who? _______________________ Most recent chest x-ray: ______________________
Alcohol consumption per week: ____

DESCRIPTION

What season(s) is condition WORSE? ____
What season(s) is condition BETTER? ____
Approximate total days absent from school or work in the past 12 months due to illness? __________
Condition is worse: [ ] Day [ ] Night [ ] Indoors [ ] Outdoors

FAMILY HISTORY

MOTHER: ___________________

FATHER: ____________________

FAMILY'S ALLERGIC HISTORY (list relationship to patient)

Asthma ______________________________ Sinus ______________________ Headaches ___________________________
Rashes ______________________________ Hay Fever __________________ Food ________________________________
Insects ____

NAME:________________________________ **DATE:**____________________ **DOB:** __________

REVIEW OF SYMPTOMS - ***Check only the ones you NOW have or have had WITHIN 48 HOURS.***

SLEEP HISTORY	SKIN	NOSE/EARS	GI	LUNGS
☐ Snoring	☐ Skin rashes	☐ Sneezing	☐ Nausea	☐ Shortness of breath When:______________
☐ Trouble falling asleep	☐ Hives	☐ Earache	☐ Vomiting	☐ Wheezing
☐ Trouble staying asleep	☐ Itching skin	☐ Nasal congestion	☐ Heartburn	☐ Chest congestion
☐ NONE	☐ Skin dryness	☐ Runny nose	☐ Diarrhea	☐ Cough
	☐ Skin sores	☐ Yellow/greenish drainage	☐ Poor appetite	☐ Phlegm
	☐ Skin color changes	☐ Sore throat	☐ NONE	☐ Coughed blood
PET EXPOSURE	☐ NONE	☐ Postnasal drip		☐ Tobacco use: ______________________
☐ Cat		☐ Pressure	**MOUTH**	☐ NONE
☐ Dog	**HEAD**	☐ Nose bleeds	☐ Mouth breathing	
☐ Other: ____________	☐ Headaches	☐ Loss of smell	☐ Oral blisters	**HEART**
☐ NONE	☐ Head injuries	☐ Itching ears	☐ Oral ulcers	☐ Chest pain: Sharp/Dull
	☐ NONE	☐ Dizziness	☐ Bad taste	☐ With activity
GENERAL		☐ Ear ringing	☐ Loss of taste	☐ After eating
☐ Weakness	**EYES**	☐ Hoarseness	☐ Bad breath	☐ Rapid heartbeat
☐ Fatigue	☐ Itching/watery eyes	☐ NONE	☐ NONE	☐ NONE
☐ Chills	☐ Eye redness			
☐ Night sweats	☐ Burning eyes		**SHOTS - LAST:**	
☐ Fainting	☐ Eye pain		☐ Flu_____________	
☐ NONE	☐ Blurred vision		☐ Pneumococcal____	
	☐ NONE		☐ Shingles_________	

ALLERGIES:____

____