Allergy History Form

Patient Name: ________________________________ *Date:* ________________________

Age: _______ *Weight*: _______ *Height:* ________ *Occupation:* ___________________________________

Please list the main reasons for your visit today: ____

____

____

Do you have any of the following symptoms? (Circle)

Sneezing	Blocked nose	Watery nose	Shortness of breath
Wheezing	Chest tightness	Cough	Sputum (phlegm)
Night symptoms	Severe itching	Severe swelling	Acid stomach

Have you been told or think you have any of the following? (Circle)

Sinusitis	Ear infection	Nasal polyps	Recurrent bronchitis
Eczema	Hives	Stomach reflux	Allergic rhinitis/hay fever
Diabetes	Tuberculosis	Frequent infection	High blood pressure

Which of the following bring on attacks of allergies or asthma? (Circle)

Cold Air	Exercise	Strong odors	Respiratory Infection
Emotions/stress	Tobacco/smoke	Weather changes	Occupational chemicals

Allergens: Pollens / Dust / Molds / Dog / Cat

Other triggers: ____

Food Allergies? ____

Drug Allergies? ____

Other Allergies? (List) ____

Insect Allergies? (Describe reaction) ____

Latex Allergies? (Rubber products) ____

What months are your symptoms worse? (Circle)

Jan. Feb. Mar. Apr. May June July Aug. Sept. Oct. Nov. Dec. None

Patient Name: ________________________________ *Date:* ________________________

When did your symptoms begin? ____

Did you have any allergy or asthma symptoms in childhood? _______________________________________

Are your symptoms constant or intermittent? ____

Symptoms worsen: (Circle) Night Mornings Evenings Home Work Indoors Outdoors

Hobbies: Indoor ____________________________ Outdoor ______________________________________

History of any other allergy evaluation? Yes ________ No ________

If so when and where? ____

Skin test results: ____

Previous allergy injections? Yes ________ No ________ Dates ____________________

Smoking: Do you smoke? Yes ________ No ________ Date stopped ____________________

Number of years smoked? ________ Approximate number packs/day ________

Family History

Allergies in close relatives: Yes ________ No ________ List them: _________________________________

____

Asthma in close relatives: Yes ________ No ________ List them: ___________________________________

____

Environmental History

How long in current home? ________ Apt. ________ How old is the building? ________

Location: City _________ Suburb ___________ Rural ___________

Is there a basement? _________ (Circle damp or dry)

What kind of heating system? Radiator/baseboard _______________ Hot air __________

Bedroom: What floor is bedroom on? __________ Bedroom carpeted? ____________

Type of pillow: ___________ Type of comforter: _____________ Any Down: Yes ___ or No ____

Mattress: Inner spring __________ Futon __________ Water _________ Foam ____________

Do you have allergy-proof covers for your pillows? __________ Mattress: ___________

Patient Name: ________________________________ *Date:* __________________________

Flooring: Hardwood __________ Area Rugs ___________ Wall-to-Wall ___________

Air conditioning: Central ____________ Separate units _____________ Humidifier ______________________

Animals in home: Yes ________ No ________ List: ____

Tobacco smoke in home: Yes ________ No ________ Who? ____

If you have or suspect you have asthma, please answer the following:

Nighttime wheezing, cough, shortness of breath: Often _________ Occasional _________ Never ____________

Limitations and symptoms: with sports or strenuous exercise ____

With any activity ________________ Symptoms are present at rest ___________________________________

Number of school/work days missed during last year (approximate) ___________________________________

Number of oral steroid (prednisone) prescriptions last year (approximate) ____________________________

Number of visits for asthma (lifetime) to emergency room ____

History of "life threatening" attacks? Yes ________ No ________

Intubated: Yes ________ No _________

Have you had any other serious illness, accidents, or hospitalizations? _______________________________

If so, when? ____

List all surgeries you have had (procedure/date): ____

____

Are you pregnant or are planning on getting pregnant? ____

Please list any questions/concerns that you would like to discuss during this visit and list what you would like accomplished with today's visit:

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____

Do you have a Health Care Proxy, Advanced Directive or Living Will? ________________________________

If yes, please identify: ____