

ALLERGY HISTORY

Instructions:

Carefully complete in full. Accuracy and thoroughness are essential. Print all answers. Relate all answers to your own experiences, not to previous advice on skin tests. This form must be completed prior to seeing the physician. *All information will be considered confidential.*

Name _____ Date of Birth _____

Name of referring physician _____
City _____ State _____ Zip _____ Phone _____

State problems you wish to discuss: _____

When did it begin? _____ (Year) How often does it occur? _____ (# times per day, week, etc.)
Worse at night or day? _____ How long does it last? _____ (Hours, days, etc.)

Check months most severe:

- | | | | |
|-------------------------------------|--------------------------------|------------------------------------|-----------------------------------|
| <input type="checkbox"/> ALL Months | | | |
| <input type="checkbox"/> January | <input type="checkbox"/> April | <input type="checkbox"/> July | <input type="checkbox"/> October |
| <input type="checkbox"/> February | <input type="checkbox"/> May | <input type="checkbox"/> August | <input type="checkbox"/> November |
| <input type="checkbox"/> March | <input type="checkbox"/> June | <input type="checkbox"/> September | <input type="checkbox"/> December |

What do you think makes it better? _____

What do you think makes it worse? _____

What do you think causes the problem? _____

Check items that affect your symptoms:

- | | | | | |
|-----------|------------------------------------------|-----------------------------------------|-----------------------------------------------------|---------------------------------------|
| Irritants | <input type="checkbox"/> Cleanser | <input type="checkbox"/> Detergent | <input type="checkbox"/> Cooking odor | <input type="checkbox"/> Perfume |
| | <input type="checkbox"/> Powder | <input type="checkbox"/> Tobacco smoke | <input type="checkbox"/> Other smoke, specify _____ | |
| | <input type="checkbox"/> Moth Balls | <input type="checkbox"/> Motor fumes | <input type="checkbox"/> Paint lacquer | <input type="checkbox"/> Wax |
| | <input type="checkbox"/> Glue | <input type="checkbox"/> Insect spray | <input type="checkbox"/> Fertilizers | <input type="checkbox"/> Ammonia |
| | <input type="checkbox"/> Room deodorants | <input type="checkbox"/> Chemical fumes | <input type="checkbox"/> Clorox | <input type="checkbox"/> Other: _____ |

- | | | | | |
|------------|-------------------------------------|--------------------------------------|----------------------------------------|------------------------------------------|
| Toiletries | <input type="checkbox"/> Soap | <input type="checkbox"/> Shampoo | <input type="checkbox"/> Shaving cream | <input type="checkbox"/> Aftershave |
| | <input type="checkbox"/> Hair spray | <input type="checkbox"/> Hair tonic | <input type="checkbox"/> Hair dye | <input type="checkbox"/> Spray deodorant |
| | <input type="checkbox"/> Hand cream | <input type="checkbox"/> Make-up | <input type="checkbox"/> Toothpaste | <input type="checkbox"/> Denture cream |
| | <input type="checkbox"/> Mouthwash | <input type="checkbox"/> Nail Polish | <input type="checkbox"/> Other: _____ | |
| | | | | |

Foods Milk Cheese Eggs Fish
Shellfish Nuts Chocolate Alcohol
Wine Beer Juices Spices
Vegetables Strawberries Wheat products Very cold liquids
Other: _____

Pets Which of these do you have as pets:
Dog Cat Bird Horse
Hamster Rabbit Other: _____

Is your condition worse around pets? Yes No
Specify: _____

Drugs Penicillin Sulfa Over-the-counter drugs, specify: _____
Other: _____

Weather Hot Cold Humid Damp
Pollution Smog Sunlight Air-conditioning
Change in temperature

New Clothing (unwashed) Wool Silk Sweater Dry-cleaned clothes
Shoes Coat Starched clothes Other: _____

Contactants Poison ivy Cut grass Cut flowers Household plants
Hay Christmas trees Plastic Rubber
Fiberglass Dust Wool blankets Feather pillows
Mattress Furs Rugs Jewelry
Rug pads Stuffed toys Overstuffed furniture

Check Symptoms Experienced

General Nervousness Dizziness Fainting Sinus trouble
Frequent colds Fatigue Other: _____

Headache Where? (front, back, right, left) _____ Day Night
Aching Throbbing Sharp Dull
With vomiting Stuffy nose Better with sleep Worse with tension
Spots before eyes

Skin Rash Hives Eczema Blisters
Itching Swelling Burning Stinging
Redness Perspiration Dandruff Athlete's foot
Where? _____ Worse after eating? Yes No

Eyes	<input type="checkbox"/> Tearing <input type="checkbox"/> Redness <input type="checkbox"/> Blurring of vision	<input type="checkbox"/> Burning <input type="checkbox"/> Discharge <input type="checkbox"/> Glaucoma	<input type="checkbox"/> Itching <input type="checkbox"/> Puffiness <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pain <input type="checkbox"/> Infections
Ears	<input type="checkbox"/> Pressure <input type="checkbox"/> Infections	<input type="checkbox"/> Itchiness <input type="checkbox"/> Deafness	<input type="checkbox"/> Drainage <input type="checkbox"/> Swelling	<input type="checkbox"/> Bleeding <input type="checkbox"/> Other: _____
Nose	<input type="checkbox"/> Sneezing <input type="checkbox"/> Itching <input type="checkbox"/> Polyps <input type="checkbox"/> Previous surgery	<input type="checkbox"/> Stuffiness <input type="checkbox"/> Cloudy discharge <input type="checkbox"/> Postnasal drip <input type="checkbox"/> Other: _____	<input type="checkbox"/> Sniffles <input type="checkbox"/> Snoring <input type="checkbox"/> Bleeding	<input type="checkbox"/> Clear running discharge <input type="checkbox"/> Difficulty in smelling <input type="checkbox"/> Broken nose
Tongue	<input type="checkbox"/> Swollen <input type="checkbox"/> Difficulty in tasting	<input type="checkbox"/> Sore <input type="checkbox"/> Other: _____	<input type="checkbox"/> Itching	<input type="checkbox"/> Coated
Mouth	<input type="checkbox"/> Itching of roof <input type="checkbox"/> Morning sore throats <input type="checkbox"/> Swollen lip <input type="checkbox"/> Change in voice	<input type="checkbox"/> Repeated tonsillitis <input type="checkbox"/> Frequent throat clearing <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Other: _____	<input type="checkbox"/> Tonsils removed <input type="checkbox"/> Bad breath <input type="checkbox"/> Mouth breathing	
Mucus	<input type="checkbox"/> Thick <input type="checkbox"/> Green	<input type="checkbox"/> Thin <input type="checkbox"/> Brown	<input type="checkbox"/> Clear <input type="checkbox"/> Bloody	<input type="checkbox"/> Yellow
	Amount per day (teaspoon, tablespoon, 1/2 cup) _____			
	Source of mucus (nose, lungs, throat) _____			
Chest	<input type="checkbox"/> Shortness of breath <input type="checkbox"/> Tightness <input type="checkbox"/> Difficulty in walking <input type="checkbox"/> Heart trouble <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer	<input type="checkbox"/> Wheeze <input type="checkbox"/> Cough <input type="checkbox"/> Difficulty in working <input type="checkbox"/> High blood pressure <input type="checkbox"/> Pneumonia <input type="checkbox"/> Other: _____	<input type="checkbox"/> Pain <input type="checkbox"/> Cough with wheeze <input type="checkbox"/> Difficulty in sleeping <input type="checkbox"/> Emphysema <input type="checkbox"/> Tuberculosis	
Stomach	<input type="checkbox"/> Vomiting <input type="checkbox"/> Belching <input type="checkbox"/> Soiling: Worse after eating what foods? <input type="checkbox"/> Other: _____	<input type="checkbox"/> Diarrhea <input type="checkbox"/> Mucus in stool	<input type="checkbox"/> Gas <input type="checkbox"/> Blood in stool	<input type="checkbox"/> Cramps <input type="checkbox"/> Foul-smelling stool
Joints	<input type="checkbox"/> Pain	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Swelling	<input type="checkbox"/> Other: _____
Menses	<input type="checkbox"/> Regular <input type="checkbox"/> Cramps Are you pregnant now? <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Irregular <input type="checkbox"/> Infections	<input type="checkbox"/> Discharge <input type="checkbox"/> Last period (date) _____ <input type="checkbox"/> Taking birth control pills: <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Itch Pain: <input type="checkbox"/> Yes <input type="checkbox"/> No
Kidneys	<input type="checkbox"/> Pain <input type="checkbox"/> Itching	<input type="checkbox"/> Frequent urination <input type="checkbox"/> Chills	<input type="checkbox"/> Bladder infection <input type="checkbox"/> Fever	<input type="checkbox"/> Recurrent infection <input type="checkbox"/> Other: _____

Are symptoms:

- Constant Erratic Rare

Do symptoms interfere with your activities?

- Not at all A little Moderately All the time

Check pertinent items and fill in the blanks.

Where do you live?

- Room Apartment Brick house Wood-framed house
 Mobile home Age of house _____

Location

- City Suburbs Country Farm
 Lakeside Desert Mountains Near factory
 Near bakery Near grain storage Near swamp Near poultry yard
 Near barn Other: _____

Problems worse in

- Bedroom Living room Kitchen Basement
 Attic Garage Indoors Outdoors
 Other: _____

Type of heating

- Forced air Radiator Electric Heat pump
 Filtered air Other: _____

Problems worse when

- At home At work In car
 Exercising Hair salon At school
 Driving in traffic Sweeping House cleaning
 Making beds Around open windows Around humidifier
 Around vaporizer Around fans Around heating ducts
 On windy days Swimming in chlorinated water
 Taking hot or cold baths In musty places Other: _____

Insect bites or stings

- Large swelling Weakness Sweating Shortness of breath
 Stuffy nose Wheezing Other: _____

Medications currently using (Please include dosage) _____

Family History

- Asthma Eczema Sinus problems Migraine
 Hayfever Ulcer Nervous disorder Colitis
 Hives Emphysema Cystic fibrosis Tuberculosis
 Thyroid disease Glaucoma Other: _____

Unusual activities engaged in just prior to onset of symptoms

Unusual food or drink ingested just prior to onset of symptoms

New environmental factors at home or at work

List any medical condition(s) for which you have been treated

List any surgery you have had

List any other conditions for which you are currently being evaluated or treated

Previous Allergy Treatment

Have you ever been treated with Allergy shots? Yes No

If yes, what were you treated for?

- | | | |
|----------------------------------------|---------------------------------------|---------------------------------------|
| <input type="checkbox"/> Grass pollens | <input type="checkbox"/> Molds | <input type="checkbox"/> Weed pollens |
| <input type="checkbox"/> Dust | <input type="checkbox"/> Tree pollens | <input type="checkbox"/> Animals |

Did the Allergy shots help you? Yes No Don't know

What year were the shots taken? _____ to _____

Other Information

Please note below any other information you would like to add
