ROBERT H. OLIVER, M.D., PLLC
OTOLARYNGOLOGY – HEAD AND NECK SURGERY & OTOLARYNGIC ALLERGY

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:

☐ALL Months

☐January	☐April	☐July	☐October
☐February	☐May	☐August	☐November
☐March	☐June	☐September	☐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	☐Cleanser	☐Detergent	☐Cooking odor	☐Perfume
	☐Powder	☐Tobacco smoke	☐Other smoke, specify_____	
	☐Moth Balls	☐Motor fumes	☐Paint lacquer	☐Wax
	☐Glue	☐Insect spray	☐Fertilizers	☐Ammonia
	☐Room deodorants	☐Chemical fumes	☐Clorox	☐Other:_____

Toiletries	☐Soap	☐Shampoo	☐Shaving cream	☐Aftershave
	☐Hair spray	☐Hair tonic	☐Hair dye	☐Spray deodorant
	☐Hand cream	☐Make-up	☐Toothpaste	☐Denture cream
	☐Mouthwash	☐Nail Polish	☐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
☐Tearing ☐Burning ☐Itching ☐Pain
☐Redness ☐Discharge ☐Puffiness ☐Infections
☐Blurring of vision ☐Glaucoma ☐Other:_____

Ears
☐Pressure ☐Itchiness ☐Drainage ☐Bleeding
☐Infections ☐Deafness ☐Swelling ☐Other:_____

Nose
☐Sneezing ☐Stuffiness ☐Sniffles ☐Clear running discharge
☐Itching ☐Cloudy discharge ☐Snoring ☐Difficulty in smelling
☐Polyps ☐Postnasal drip ☐Bleeding ☐Broken nose
☐Previous surgery ☐Other:_____

Tongue
☐Swollen ☐Sore ☐Itching ☐Coated
☐Difficulty in tasting ☐Other:_____

Mouth
☐Itching of roof ☐Repeated tonsillitis ☐Tonsils removed
☐Morning sore throats ☐Frequent throat clearing ☐Bad breath
☐Swollen lip ☐Trouble swallowing ☐Mouth breathing
☐Change in voice ☐Other:_____

Mucus
☐Thick ☐Thin ☐Clear ☐Yellow
☐Green ☐Brown ☐Bloody
Amount per day (teaspoon, tablespoon, ½ cup)_____
Source of mucus (nose, lungs, throat)_____

Chest
☐Shortness of breath ☐Wheeze ☐Pain
☐Tightness ☐Cough ☐Cough with wheeze
☐Difficulty in walking ☐Difficulty in working ☐Difficulty in sleeping
☐Heart trouble ☐High blood pressure ☐Emphysema
☐Bronchitis ☐Pneumonia ☐Tuberculosis
☐Cancer ☐Other:_____

Stomach
☐Vomiting ☐Diarrhea ☐Gas ☐Cramps
☐Belching ☐Mucus in stool ☐Blood in stool ☐Foul-smelling stool
☐Soiling: Worse after eating what foods? _____
☐Other: _____

Joints
☐Pain ☐Stiffness ☐Swelling ☐Other:_____

Menses
☐Regular ☐Irregular ☐Discharge ☐Itch
☐Cramps ☐Infections ☐Last period (date)_____ Pain: ☐Yes☐No
Are you pregnant now? ☐Yes ☐No ☐Taking birth control pills: ☐Yes ☐No

Kidneys
☐Pain ☐Frequent urination ☐Bladder infection ☐Recurrent infection
☐Itching ☐Chills ☐Fever ☐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?

☐ Grass pollens ☐ Molds ☐ Weed pollens
☐ Dust ☐ Tree pollens ☐ 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