ALLERGY PROFILE

Symptoms of Common Allergies

Patient Name: _____ **Date:** _____

PLEASE PLACE A ✓ BESIDE THE PROBLEMS YOU ARE EXPERIENCING

☐ SNEEZING	☐ WATERY EYES	☐ THROAT DRAINAGE	☐ THROAT TICKLE
☐ RUNNY NOSE	☐ SWOLLEN LIDS	☐ BLOCKED EARS	☐ WHEEZING
☐ BLOCKED NOSE	☐ ITCHY EYES	☐ ITCHY EARS	☐ TIGHTNESS IN CHEST
☐ LOSS OF SMELL	☐ SORE THROAT	☐ EAR INFECTION	☐ SHORTNESS OF BREATH
☐ HEADACHE	☐ ITCHY MOUTH	☐ COUGH	

Caused by: _____

☐ SKIN ITCH	☐ SWELLING OF LIPS	☐ NAUSEA	☐ IRRITABILITY
☐ RASH	☐ ITCHY HANDS OR FEET	☐ DIARRHEA	
☐ HIVES OR WELTS	☐ STOMACH PAINS	☐ FATIGUE	

1. **When did symptoms start?** _____

2. **What is the worst time of the year?**	☐ Spring	☐ Summer	☐ Fall	☐ Winter
3. **What is the best time of the year?**	☐ Spring	☐ Summer	☐ Fall	☐ Winter
4. **What triggers your symptoms?**	☐ Weather	☐ Exertion	☐ Infection	

Present Medications: _____

Previous treatment: ☐ Allergy Testing ☐ Allergy Shots ☐ Other Medications

Are you allergic to any of the following:

☐ ANIMALS	☐ FOODS	☐ INSECTS
☐ DUST	☐ MEDICINES	☐ SMOKE

What medications are you allergic to? _____

Family History:

Does anyone in your family have allergies? ☐ YES ☐ NO ☐ Unkown (If yes, check below)

☐ FATHER ☐ MOTHER ☐ BROTHER ☐ SISTER ☐ CHILDREN

Is anyone in your family a patient here? ☐ YES ☐ NO

Home Environment:

Your house is ☐ OLD ☐ NEW

Does your home have:

☐ CARPET ☐ AIR CONDITIONING ☐ PLANTS ☐ PETS ☐ SMOKER IN HOUSE

Additional Comments? _____