# ALLERGY HISTORY

Name ________________________________________ Birth Date _______________________ Age ______

Occupation or employment ___________________________ Prev. Employment _________________________

Chief Problems (describe briefly) _________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________

Review of Allergy History (<u>Please check or complete where appropriated)</u>

**ALLERGIC RHINITIS**

(Nasal symptoms, hay fever, etc.)

Age of onset of earliest symptoms ________________

Frequency of symptoms:

Constant ____ Daily ____ Weekly ____ Monthly ____

Are symptoms year round Yes ____ No ____

Are symptoms worse:

in the fall _________ in the winter _________

in the spring _______ in the summer _______

Are the symptoms getting:

Worse ______ Better ______ Staying the same _______

Description of symptoms:

Nasal blockage Yes ____ No ____

Nasal congestion Yes ____ No ____

Decreased hearing Yes ____ No ____

Pain/pressure in ears Yes ____ No ____

Sneezing episodes Yes ____ No ____

Nose rubbing or itching Yes ____ No ____

Sniffing Yes ____ No ____

Post-nasal drainage Yes ____ No ____

Clearing of the throat Yes ____ No ____

Loss of taste, smell Yes ____ No ____

Runny nose Yes ____ No ____

Are symptoms aggravated by:

Housedust Yes ____ No ____

Feather pillows Yes ____ No ____

Animal danders Yes ____ No ____

Sprays or chemicals Yes ____ No ____

Cosmetics Yes ____ No ____

Flowers in the house Yes ____ No ____

Emotional upsets Yes ____ No ____

Respiratory infections Yes ____ No ____

Smoke Yes ____ No ____

Other ___________________________________

________________________________________

Are symptoms worse or aggravated at:

Home ____ Work ____ School ____ Church ____

Visiting farm _____ Elsewhere _______________

Have you ever had or received treatment for

Remarkable nose bleeds Yes ____ No ____

Nasal polyps Yes ____ No ____

Nasal septal deformity Yes ____ No ____

Sinus operations or washings Yes ____ No ____

Broken nose Yes ____ No ____

List medications taken for nasal symptoms:

**ALLERGIC CONJUNCITIVITIS**

Do you have eye symptoms Yes ____ No ____

Age of onset of earliest symptoms ______________

Description of symptoms:

Eye redness Yes ____ No ____

Itching Yes ____ No ____

Watering Yes ____ No ____

Mattering Yes ____ No ____

Are symptoms worse:

Spring Yes ____ No ____

Summer Yes ____ No ____

Fall Yes ____ No ____

Winter Yes ____ No ____

All year round Yes ____ No ____

What aggravates symptoms ___________________

_________________________________________

**HEADACHES**

Do you have headaches Yes ____ No ____

Age of onset of earliest symptoms ____________

Are headaches:

Daily ____ Weekly ____ Monthly ____

Other ___________________________________

Area of headaches:

Side of head ________ Frontal ________

Back of neck ________ One-sided _____

Other ___________________________________

Severity:

Mild ______ Moderate ______ Severe ______

Throbbing ______ Nauses with headaches ______

Disturbance of vision _____ Are there any symptoms prior to onset of headaches Yes ____ No ____

Describe: ________________________________

_________________________________________

Do medications help: Yes ____ No ____

**ECZEMA**

Have you ever had eczema Yes ____ No ____

Age of earliest symptoms ______________________

Still present Yes ____ No ____

Age of clearing ______________________________

Areas now involved __________________________

_________________________________________

List of all known suspected offenders that aggravate eczema ___________________________________

_________________________________________