ALLERGY HISTORY

Name _____ Birth Date _____ Age _____

Occupation or employment _____ Prev. Employment _____

Chief Problems (describe briefly) _____

_____

_____

Review of Allergy History (Please check or complete where appropriated)

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 _____

_____

_____ _____

URTICARIA (HIVES)

Have you ever had hives: Yes ____ No ____
Age of onset of earliest symptoms _____
Frequency
Daily Yes ____ No ____
Weekly Yes ____ No ____
Monthly Yes ____ No ____
Other _____
Location:
Face Yes ____ No ____
Trunk Yes ____ No ____
Arms Yes ____ No ____
Legs Yes ____ No ____
Hands Yes ____ No ____
Feet Yes ____ No ____
Other _____
Are hives small Yes ____ No ____
Are hives large Yes ____ No ____
Is there associated swelling Yes ____ No ____
Breathing difficulties Yes ____ No ____
Are there any family members with hives or swelling attacks Yes ____ No ____
Do you have dental problems Yes ___ No ___
List all known or suspected things that cause hives, including foods: _____
_____
List all soaps used, oils, skin lotions, creams, etc. _____
_____
_____
_____

FOOD ALLERGY

Are you allergic to any foods Yes ___ No ___
Please list:
Food Date Reaction
_____
_____
_____
_____

INSECT SENSITIVITY

Have you ever had severe reaction from insect stings or bites? Yes ___ No ___
Was the bite or sting from:
Mosquito ___ Bee ___ Wasp ___
Bumble Bee ___ Yellow Jacket ___
Sweat Bee ___ Hornet ___
Other _____
Description of symptoms:
Swelling: Mild ___Moderate ___Generalized __
Breathing Difficulties Yes ___ No ___
Hives Yes ___ No ___
Fainting Yes ___ No ___
Other symptoms _____
_____

BRONCHIAL ASTHMA

(Chest congestion, wheezing)
Age of onset of earliest symptoms
Description of symptoms:
Wheezing Yes ____ No ____
Tightness in chest Yes ____ No ____
Cough Yes ____ No ____
Dry Yes ____ No ____
Productive Yes ____ No ____
Amount _____
Daily Yes ____ No ____
Periodic Yes ____ No ____
Worst during day Yes ____ No ____
Worst during night Yes ____ No ____
Chest pain Yes ____ No ____
Shortness of breath Yes ____ No ____
with exercise Yes ____ No ____
with rest Yes ____ No ____
with cold air Yes ____ No ____
Frequency of asthma symptoms:
Daily _____ Weekly _____ Monthly _____
Are symptoms getting:
Worse ___ Better _____ Staying same
_____
Is Asthma all year round?
Worse in fall ____ Worse in winter ____
Worse in spring ____ Worse in summer ___
Is Asthma aggravated by:
Infections Yes ____ No ____
Housedust Yes ____ No ____
Cold weather Yes ____ No ____
Dampness Yes ____ No ____
Every infection Yes ____ No ____
Outside dust Yes ____ No ____
Hot weather Yes ____ No ____
High humidity Yes ____ No ____
Animal exposure Yes ____ No ____
Other Yes ____ No ____
_____
List medications now taken for asthma:
_____ _____
_____ _____
_____ _____
_____ _____
List hospitalizations for asthma, if any, name of hospital and dates:

_____ _____ _____ MSG (Chinese Food)
_____ _____ _____ Preservatives
_____ _____ _____ Menthol
_____ _____ _____ Alcohol
_____ Sulfites

Do you have any problem with the following:

PAST MEDICAL HISTORY

DIABETES	Yes _____ No _____	KIDNEY DISEASE	Yes _____ No _____
EMPHYSEMA	Yes _____ No _____	LIVER DISEASE	Yes _____ No _____
FACIAL TRAUMA	Yes _____ No _____	LUNG DISEASE	Yes _____ No _____
GLAUCOMA	Yes _____ No _____	PREGNANT	Yes _____ No _____
HEART DISEASE	Yes _____ No _____	THYROID DISEASE	Yes _____ No _____
HYPERTENSION	Yes _____ No _____		

CHEST X-RAY DATE _____ RESULT _____
SINUS X-RAY DATE _____ RESULT _____

Do you smoke? Yes _____ No _____
Packs per day _____ How many years _____

Tonsilectomy and/or adenoidectomy Yes _____ No _____
Frequent infections Yes _____ No _____ Number per year ___ TYPE _____

MEDICATION HISTORY

Have you ever had adverse symptoms from aspirin? Yes _____ No _____
If so, describe symptoms _____

List all other medications used for allergy or other conditions including those taken orally, injected or ointments for the skin

Medications presently and or previously	**Date and How Often used**	**Helped**	**No help**	**Describe any reactions ill –effects**
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Have you ever had drug allergies or reactions? Yes _____ No _____
Describe

Drug	**Date Taken**	**Reactions**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY HISTORY

1.	Nasal Polyps	Yes _____	No_____
2.	Aspirin Sensitivity	Yes _____	No_____
3.	Food Allergy	Yes _____	No_____
4.	Drug Allergy	Yes _____	No_____
5.	Insect Allergy	Yes _____	No_____
6.	Psoriasis	Yes _____	No_____
7.	Skin Allergy	Yes _____	No_____
8.	Colic	Yes _____	No_____
9.	Auto Motion Sickness	Yes _____	No_____
10.	Brochitis	Yes _____	No_____
11.	Diabetes	Yes _____	No_____
12.	Thyroid	Yes _____	No_____
13.	Arthritis	Yes _____	No_____
14.	Hormonal Problems	Yes _____	No_____
15.	Asthma	Yes _____	No_____
16.	Hayfever	Yes _____	No_____
17.	Eczema	Yes _____	No_____
18.	Emphysema	Yes _____	No_____
19.	Frequent Infections	Yes _____	No_____
20.	Sinus Problems	Yes _____	No_____
21.	Tuberculosis	Yes _____	No_____
22.	Migraine Headaches	Yes _____	No_____
23.	Hives	Yes _____	No_____
24.	Cystic Fibrosis	Yes _____	No_____

ENVIRONMENTAL SURVEY:

Time lived in present home _____ Approximately how old is dwelling _____

City _____ Rural _____ Apartment _____ (Older _____ Newer _____)

Do you have pets at home? Yes ____ No ____ Cat ____ Dog ____ Birds ____ Other _____

If you live on afarm, are you exposed to: Chickens ____ Horses ____ Cattle ____ Sheep ____

Hogs ____ Barns ____ Grains ____ Other _____

Bedroom

Pillows: Feather ____ Dacron ____ Foam ____ Encased ____ Other _____

Bed Coverings: Wool blankets ____ Quilts or comforters ____ Other _____

Mattress: How old _____ Made of: Cotton ____ Foam ____ Encased ____ Other _____

Stuffed animals? Yes ____ No ____ Rugs: Carpet Yes ____ No ____ Type : Syntethic ____ Nylon ____

Home in General Heat: Gas ____ Oil ____ Electric ____ Space Heater ____ Other _____

Humidification: Good ____ Fair ____ Poor ____ Type: Furnace ____ Room ____ Vaporizer ____

Do you have electronic air filter: Yes ____ No ____

Is your basement Dry ____ Damp ____ Musty ____ Finished ____ Dehumidified: Yes ____ No ____

Do you have air conditioning? Yes ____ No ____ Type: Room ____ Central ____

Does anyone smoke in the home? Yes ____No ____

Locations of previous residences:

City	**Symptoms better, worse, or the same**
_____	_____
_____	_____
_____	_____

Explain any unusual allergy exposures at home or work: Dust, fumes, odors, sawdust, fertilizers, paint, etc. _____

_____

Have you had any previous allergy tests and/or treatments? Yes ____No ____ If so, where and by whom:

_____

_____