

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 CONJUNCTIVITIS

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 _____ Nauseas 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 _____
