

Allergy History

Patient Name:

Date:

Date of Birth:

SSN#:

Personal Physician:

Referred: Y/N

Street

City

State

Zip

Age

Sex

Race

Telephone

State problems you wish to discuss:

When did it begin?

1. During which months do symptoms occur? All months

January

April

July

October

February

May

August

November

March

June

September

December

2. Are symptoms worse? Morning Afternoon Evening Night
At Home At Work (School) Other Location:

3. Are Symptoms? Constant Erratic Rare

4. Do symptoms interfere with your activities? Not at all A little
Moderately All the time

5. Can you relieve your symptoms? How?

6. Do any of the following cause or make your symptoms worse?

Milk

Fruit or juices

Vegetables

Eggs

Beer

Wine

Wheat products

Liquors

Nuts /beans/seeds

Cheese

Meat

Mushrooms

Vinegar

Chicken

Poultry

Fish

Other:

7. Are your symptoms made worse by? Wind Smoke Barns/Hay
 High pollution day Damp areas Soap Powder
 Mowing lawns Insecticides Dust Paint fumes
 Perfumes Cats Cosmetics Dogs
 Newspapers Other animals Wool House Plants
 Weather change Wet weather Dry weather
 Hot day Cold day Air conditioning
 Travel/Vacations Indoors Outdoors

Name:

Date:

ID#:

8. Unusual activities engaged in just prior to onset of symptoms:

9. Unusual food or drink ingested just prior to onset of symptoms:

Other Information

Please note below any other information you'd like to add:

Circle any other symptoms brought on by your problem or that you might have:
(Fill in blanks where necessary.)

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. Cause: migraine, food, sinus, tension, drug, other:

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, itching, clear running discharge, cloudy discharge, trouble smelling, snoring, polyps, post-nasal drip, bleeding, broken nose, previous surgery, other:

Tongue Swollen, sore, itching, coated, trouble tasting, other:

Mouth Itching of roof, repeated tonsillitis, tonsils removed, morning sore throats, bad breath, swollen lip, trouble swallowing, mouth breathing, frequent throat clearing, change in voice, other:

Mucus Thick, thin, clear, yellow, green, brown, bloody, amount per day (teaspoon, tablespoon, 1/2 cup), source of mucus (nose, lungs, throat)

Chest Shortness of breath, wheeze, pain, tightness, cough, cough with wheeze, trouble walking, trouble working, trouble sleeping, heart trouble, high blood pressure, emphysema, bronchitis, pneumonia, tuberculosis, cancer, other:

Stomach Vomiting, gas, cramps, belching, diarrhea, : worse after eating what foods? Other:

Name:

Date:

ID#:

Joints Pain, stiffness, swelling, other:

Menses Female only. Regular, irregular, discharge, itch, cramps, infections, last period (date): . Are you pregnant now? Yes/No Taking birth control pills Yes/No

Kidneys Pain, frequent urination, bladder infection, recurrent infection, itching, chills, fever, other:

Please, Circle pertinent items and fill in the blanks:

Where do you live? Apartment, House, Mobile Home? Age of building New/Old? Pets? (describe:)

Type of heating: Forced air, radiator, electric, heat pump, filtered air, other:

Type of cooling: Central Air Conditioning, Swamp Cooler, Other:

Mattress Bed or Water Bed? Carpeting Wall to wall, partially, wood floors/linoleum?

Previous Allergy Treatment

1. Have you had previous Allergy Tests? Yes/ No What did you test positive to?

2. 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

3. Did the Allergy Shots help you? Yes/ No/Don't Know

4. What years were the shots taken? 19_ to 19_ or 20__

6. Your Medical Conditions: High blood pressure Heart disease

Asthma Stomach or intestinal disease Bronchitis

Thyroid disease Emphysema Diabetes

Skin Disease Cancer Arthritis

Other:

Bee/Ant sting allergy? Yes/ No/ Don't Know What happens?

Drug allergy (list:)

Food allergy (list:)

Prior Surgery (list:)

Name:

Date:

ID#:

Medications you are taking, please include things bought "Over The Counter" as well as dosages. (list:)

Smoking habits:Cigarettes, cigars, pipe, number per day:
How long?(years)

Place age of family member having any of the following conditions in the appropriate space:

Condition	Father	Mother	Brothers	Sisters	Children	Other
Heart Disease						
High Blood Pressure						
Cancer						
Thyroid Disease						
Diabetes						
Asthma						
Allergies						
Hives						
Eczema						
Migraines						
Other						

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