

ALLERGY HISTORY

NAME: _____ DATE OF BIRTH: _____

1. WHY DID YOU SEEK MEDICAL CARE? _____

2. DO YOU HAVE OR HAVE YOU BEEN TOLD YOU HAVE ANY OF THE FOLLOWING PROBLEMS?

(Check all of the below which you feel you have)

NASAL	EYES/EARS	PULMONARY	FOR DOCTOR
Sneezing _____	Red eyes _____	Shortness of breath _____	SXR _____
Itchy nose _____	Itchy eyes _____	Chest tightness _____	MCT _____
Stuffy nose _____	Watery eyes _____	Wheezing _____	CXR _____
Runny nose _____	Gritty feeling _____	Cough _____	ENT _____
Post nasal drip _____	Frequent _____	Sputum _____	CT _____
Throat itching _____	Ear Infections _____		
Sore throat _____	Itchy Ears _____		
Nose bleeding _____		Impaired Social Functioning _____	
Snoring _____	SKIN/GI	Reduced School Performance _____	
Reduced sense of smell or taste _____	Hives _____	Inability to keep up with other children at play _____	
Poor sleep _____	Skin rash _____	Headaches - Sinus _____	
Frequent colds _____	Nausea _____	Headaches - Migraine _____	
Long Lingering colds _____	Vomiting _____	Swelling of feet, hands, or other body parts _____	
Mouth breathing _____	Diarrhea _____	Fatigue _____	
	Weight loss _____	Impaired Concentration _____	
	Itchy skin _____	Irritability _____	

2A. DO YOU THINK YOU MAY BE PREGNANT? Yes No

3. WHEN DID ALLERGY SYMPTOMS FIRST OCCUR? Month _____ Year _____

Are the symptoms seasonal _____ or all year around? _____

Which months are worse?

Jan___ Feb___ Mar___ Apr___ May___ Jun___ Jul___ Aug___ Sep___ Oct___ Nov___ Dec___

How many days did you miss from work? _____ School days? _____

What is the worst time of the day for you?

Awakening___ Morning___ Afternoon___ Evening___ Night___ All the time___

Check any of the following factors you think bother you:

Pets _____	Bright lights _____
Dust _____	Chilling _____
Molds _____	Drafts _____
Trees _____	Paint _____
Grasses _____	Varnish _____
Weeds _____	Flowers _____
Colds _____	Temperature changes _____
Air conditioning _____	Exercise _____
Fabrics _____	Soaps _____
Industrial fumes _____	Smoke _____
Insecticides _____	Newsprint _____
Worry _____	Strong odors _____
Tension _____	Rain _____
Cosmetics _____	Dampness _____
Perfumes _____	Menstrual period _____
Smog _____	OTHER: _____

OTHER: _____

OTHER SYMPTOMS YOU ATTRIBUTE TO AN ALLERGIC REACTION:

3A. REFLUX SYMPTOM INDEX	
<i>Within the last MONTH, how did the following problems effect you?</i> (0 = no problem, 5 = severe problem)	
1. Hoarseness or a problem with your voice	0 1 2 3 4 5
2. Clearing your throat	0 1 2 3 4 5
3. Excess throat mucous or postnasal drip	0 1 2 3 4 5
4. Difficulty swallowing food, liquids, or pills	0 1 2 3 4 5
5. Coughing after you ate or after lying down	0 1 2 3 4 5
6. Breathing difficulties or choking episodes	0 1 2 3 4 5
7. Troublesome or annoying cough	0 1 2 3 4 5
8. Sensations of something sticking in your throat or a lump in your throat	0 1 2 3 4 5
9. Heartburn, chest pain, indigestion, or stomach acid coming up	0 1 2 3 4 5
Total	

4. IF YOU HAVE ASTHMA, WHEEZING OR SHORTNESS OF BREATH:

Age at onset? _____ Number of hospitalizations for asthma? _____

Trips to Emergency Room, same day pediatrics, etc. for asthma in the last 12 months? _____

Number days lost from school? _____ Number of days lost from work? _____

Is your activity restricted in any way by asthma? _____

Are you awakened at night? _____ why? _____

Which of the following make your asthma worse:

cold air _____ cold symptoms _____ exercise _____ animals _____ stress _____
pollens _____ menstrual period _____ emotional upset _____ molds _____

Are there months when your asthma seems to be worse? (check the worst months)

Jan _____ Feb _____ Mar _____ Apr _____ May _____ Jun _____ Jul _____ Aug _____ Sep _____ Oct _____ Nov _____ Dec _____

A. Are you taking any of the following medications? Proventil® Ventolin® Maxair™ Brethaire®
 Alupent® Tonalate® Primatene® Mist Bronkometer® Metaprel® Serevent®

B. Are you using more than one canister per month of any of the above medications? Yes No
If yes, how many? _____

C. Are you using your inhaled bronchodilator more than three or four times a day? Yes No
If yes, how many times? _____

D. Are you taking any other asthma medications not listed in question A? Yes No If yes, what medication(s)? _____

E. Do you experience wheezing attacks more than once or twice per week? Yes No If yes, how often? _____/wk

F. Do you wake up at night with asthma symptoms more than twice a month? Yes No If yes, how often? _____/mo.

G. Do you have a hard time breathing when you exercise? Yes No

Have you ever taken steroids, eg: prednisone? _____

During active episodes of asthma, have you ever been intubated, had a seizure, stopped breathing? _____

If you have been hospitalized, how long do you usually stay in the hospital, in number of days? _____

5. PAST MEDICAL HISTORY:

HOSPITALIZATIONS: _____

SURGERIES: _____

EMERGENCY ROOM VISITS _____

6. SOCIAL HISTORY:

You are: single / married / divorced

Education status: _____ Hobbies: _____

Current Occupation: _____ Past Occupation _____

Do you smoke? Yes _____ No _____ Did you smoke in the past? Yes _____ No _____

If yes, when did you quit?

How many packs a day? _____ No. years? _____ Anyone in your home smoke? Yes _____ No _____

7. FAMILY HISTORY:

List family members with allergies, asthma, chronic cough, sinus problems or frequent infections:
Family history Emphysema, Bronchiectasis, Liver Disease?

8. ENVIRONMENTAL HISTORY:

Home/Apartment Length of Occupancy _____

Heat: Central/Radiator **Air Conditioner:** Central/Window **Air Cleaner:** Yes/No

Humidifier: Yes/No **De-humidifier:** Yes/No

Is your basement or crawl space damp? Yes/No

Is your bedroom carpeted/hardwood/vinyl/tile? Other _____

List pets: _____

List bedroom pets _____

Do your symptoms get better when you go on trips? Yes/No

MISCELLANEOUS

Have you tried prescription nasal sprays? yes no Name _____

Do asthma inhalers make you jittery? yes no Name _____

Do antihistamines make you drowsy? yes no Name _____

Have you ever been told you have hepatitis/HIV/AIDS? yes no

9. CURRENT MEDICATIONS

	Name of medication	Strength	Dose/Frequency
1.	_____		
2.	_____		
3.	_____		
4.	_____		
5.	_____		
6.	_____		

10. ARE THERE ANY FOODS YOU CAN'T TOLERATE? List them and explain why: _____

11. HAVE YOU EVER HAD A REACTION TO A DRUG? Describe: _____

12. HAVE YOU EVER HAD A REACTION TO A STINGING INSECT? Describe: _____

13. REVIEW OF SYSTEMS: Please circle if you have any on the following:

Constitutional symptoms: fever, nights sweats, weight loss, loss of appetite, depression _____

Skin: pigment changes, rash, blue fingers or toes _____

MSS: arthritis, pain, deformity, stiffness _____

Eye: double vision, visual disturbances, glaucoma, cataracts _____

ENT: dizzy spells, fainting spells, voice changes, swallowing difficulty _____

Breasts: mass, discharge, tenderness _____

CV: palpitations, chest pain, angina, murmurs, circulatory problems, high blood pressure _____

GI: indigestion, reflux, pain, nausea, diarrhea, constipation, blood, cramps, regurgitation _____

GU: urinary difficulty, blood in urine, painful urination _____

CNS: numbness, weakness, seizures, strokes, problems with balance, ADD _____

Hem/Onc: cancer, bleeding disorders, bruises _____

Endocrine: diabetes, thyroid disease, high cholesterol _____

Psychiatric disorders _____

Patient initials: _____

14. PAST ALLERGY HISTORY: Previous Allergy Testing Yes No

If YES then answer the questions below

Testing by Dr. _____ in _____ .

Previous allergy shots Yes No

Still on allergy shots Yes No

Shots are received every _____ weeks now.

Allergy shots have helped Yes No

Only minor local reactions with the shots Yes No

If major reactions then explain: _____

FOR DOCTOR
PF
EPF
D
C