ALLERGY HISTORY

Date: _____

Patient's Name: _____ Sex: ____ Age: _____

Street: _____ City: _____ State: ____ Zip: _____

Home Phone: _____ Parent's Name: _____
Area Code Number Last First Initial

To be filled out by patient.

Your answers to the following questions will help to determine the cause of your allergy symptoms. It is important to check **(√)** each question as accurately as possible.

	Yes	No	Don't Know
Have trouble with your skin?			
Eczema			
Hives			
Have trouble with your ears?			
Popping			
Itching			
Hearing loss			
Fluid in ears			
Infection/Pain			
Have trouble with your throat?			
Frequently sore/drainage			
Itching throat/mouth			
Have trouble with your eyes?			
Redness			
Itching			
Tearing			
Puffiness			
Have trouble with your nose?			
Clear/colorless discharge			
Thick/colored discharge			
Nasal itching/rubbing			
Constant stuffiness			
Periodic stuffiness			
Sniffles			
Sneezing			
Mouth breathing or snoring			
Have trouble with your chest?			
Wheezing with colds			
Wheezing when exposed to dust, pollen, animal, etc.			
Wheeze/cough after exercise			
Cough? What kind?			
Deep or productive			
Loose			
Constant			
Dry/tight			
Daytime			
Nighttime			
Are your symptoms mild?			
Moderate			
Severe			
Present most of the time			
Present part of the time			
Present rarely			
Interfering with your life			
Preventing many normal activities			

Which of the following do you think causes your symptoms or make them worse?	Yes	No	Don't Know
Indoors			
Outdoors			
At home			
At work			
Morning			
Afternoon			
At night			
Weather change			
Wet weather			
Dry weather			
Windy day			
Hot day			
Cold day			
Air conditioning			
In barns			
Damp areas			
Hay, circus			
Mowing lawn			
Dusty environment			
High air pollution			
Animals			
Cooking odors			
Smoke			
Soap powder			
Insecticides			
Paint fumes			
Perfumes			
Cosmetics			
Wave sets			
Newspapers			
Wool			
Road dust			
Milk or milk products			
Eggs			
Wheat products			
Nuts, beans or seeds			
Chocolate			
Fish			
Meat			
Fruit			
Vegetables			
Alcoholic beverages			
Cheese, mushrooms			
Beer			
Wine			
Aspirin			

Chemicals (list): _____

Drugs (list): _____

During which months do you usually have symptoms?	Yes	No	Don't Know
All Months			
January			
February			
March			
April			
May			
June			
July			
August			
September			
October			
November			
December			

Describe what symptoms bother you most
_____
_____
_____

When did your condition begin?
_____

Do you use medication regularly for nasal symptoms?	Yes	No	Don't Know

What medication?
_____

Does it help?	Yes	No	Don't Know

	Yes	No	Don't Know
Do any of your blood relatives have allergies?			
Have you ever had skin tests for allergies?			
Do you have allergies?			

What are you allergic to?
_____
_____

Is there anything else about your problem which you think might be unusual or important?	Yes	No	Don't Know

_____
_____
_____
_____

	Yes	No	Don't Know
Poison Ivy Problem?			
Insect Sting Reactions?			

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	Yes	No	Don't Know
Smokers in your home?			
Do you smoke?			
Cigarettes #_____ /day			
Pipe # _____ /day			
Cigars # _____ /day			
Years Smoked?_____			
Stopped Smoking in _____ (year)			

	Yes	No	Don't Know
Do you take medications daily or frequently?			
Aspirin			
Cortisone			
Laxatives			
Sedatives			
Birth Control Pills			
Vitamins			
Ointments			
Nose drops/sprays			
Hormones			
Others (list)			
_____			
_____			

	Yes	No	Don't Know
Do you spend a good deal of time in activities?			
Photography			
Carpentry			
Camping			
Sewing			
Gardening			
Painting			
Cooking			
Movies			
Hobbies (list)			
_____			
_____			
_____			
Sports (list)			
_____			
_____			
_____			
Other (list)			
_____			
_____			
_____			

	Yes	No	Don't Know
Do you have animals in your home?			
Have you ever had animals in your home?			
Dog			
Cat			
Bird			
Rodent			
Other (list)			
_____			
_____			

	Yes	No	Don't Know
Dou you live in: House?			
Apartment?			
In the city?			
In the suburbs?			
Is your dwelling: New?			
3 - 10 years old?			
11 - 25 years old?			
> 25 years old?			

	Yes	No	Don't Know
Have you had any of the following?			
High blood pressure			
Migraine headaches			
Skin disease			
Heart disease			
Frequent headaches			
Sinus disease			
Stomach disease			
Asthma			
Nasal polyps			
Emphysema			
Broken nose			
Overactive thyroid			
Bronchitis			
Nasal surgery			
Underactive thyroid			
Hay fever			
Deviated septum			
Hormonal difficulty			
Hives			
Food allergy			
Drug allergy (describe)			
_____			
_____			
Other conditions (describe)			
_____			
_____			

	Yes	No	Don't Know
Are you taking medication for any of the previous conditions?(describe)			
_____			
_____			
Do you think your occupation has anything to do with your symptoms?			
Describe your occupation:			
_____			
_____			
Are any materials used in your occupation that you think have something to do with your condition?			
Describe:			
_____			
_____			
_____			

At work are your symptoms			
Better			
Worse			
The same			

	Yes	No	Don't Know
Do you sleep with a pillow?			
Is it dacron?			
Is it foam rubber?			
Is it feather?			
Other (describe)			
_____			
Is your mattress cotton?			
Feather?			
Foam rubber?			
Horse hair?			
Other (describe)			
_____			

	Yes	No	Don't Know
Do you use a humidifier?			
Do you have an air conditioner?			
At work			
At home			
In bedroom			
Central			

	Yes	No	Don't Know
Is your heating system oil?			
Gas			
Coal			
Electric			
Other (describe)			
_____			
_____			

	Yes	No	Don't Know
Is heat delivered by blower?			
Radiators			
Electric Panels			
Other (describe)			
_____			
_____			