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ALLERGY HISTORY

Instructions:

Carefully complete in full. Accuracy and thoroughness are essential. Print all answers. Relate all answers to your own experiences, not to previous advice on skin tests. This form must be completed prior to seeing the physician. *All information will be considered confidential.*

Name_____ Date of Birth_____

Name of your primary physician_____ Street_____
City_____Zip_____ Phone_____

State problems you wish to discuss:_____
_____

When did it begin? _____ (Year) Worse at night or day?_____

How often does it occur?_____(# times per day, week, etc.) How long does it last?_____ (Hours, days, etc.)

Check months most severe:

__ALL Months

__January __February __March

__April __July __May__August __June __September

__October __November__December

What do you think makes it better?_____
_____

What do you think makes it worse?_____
_____

What do you think causes the problem?_____
_____

Check Symptoms Experienced:

General:

__Headaches __Sinus Pressure __Sinus Congestion __Post Nasal Drip __Sneezing __Runny Nose

__Poor Sleep __Snoring __Itchy Eyes __Plugged Ears __Ear Infections __Dizziness __Gastric Reflux

Chest:

__Shortness of Breath __Tightness __Wheezing __Diagnosed With Asthma __Cough __CPAP

__Emphysema __Tuberculosis __Heart Trouble __Bronchitis __Smoker (any kind)

If you have asthma, what triggers it?

__Animals __Exercise __Perfumes & Chemicals __Smoke & Smog __Cold Air __Changes in Weather

__Sickness such as colds, sinus infections, etc. __Seasonal Pollens, Molds __Dust __Cutting Grass

__Other:_____

Skin:

__Hives __Itching __Eczema __Rash __Other:_____

Do you experience any of these symptoms when in contact with items such as cut grass, wool, dust, animals, jewelry? If yes, please indicate:_____

Other:

Have you had life-threatening reaction to or been diagnosed as having bee venom allergy? __Yes __No

List Your Medications:

_____

_____

Please list any allergies to medications:_____

_____

Check items that affect your symptoms:

Irritants:

__Cleansers __Perfumes __Cigarette Smoke __Car Exhaust __Chemical fumes __Other:_____

Toiletries:

__Soap __Shampoo __Skin Lotion __Make-up __Hair Dye __Other:_____

Foods:

__Milk __Shellfish __Peanuts __Nuts __Wine/Beer __Eggs __Fish __Strawberries __Melon __Apples __Bananas __Celery __Carrots __Spices

Pets & Animals: Do you have pets in the home? __Yes __No Please check any that cause symptoms:

__Dog __Cat __Bird __Rabbit __Horse __Hamster __Guinea Pig __Other: _____

Weather:

__Hot __Cold __Damp __Changes in temperature __Humid __Smog or Pollution

Check items describing your home and environment:

Where do you live? __House __Apartment __Mobile Home Age of home? _____

Location of home: __City __Lakeside __Suburbs __Country __Near farm or orchards __Near swamp/marsh

Type of heating: __Forced Air Furnace __Radiator __Electric __Heat Pump

Do you have air conditioning? __ Yes __No Dehumidifier? __Yes __No

Keep windows open to outside air? __Yes __No

Use a vaporizer? __Yes __No Have an attic? __Yes __No Have a basement? __Yes __No

Previous allergy treatment:

Tested before? __Yes __No If yes, when and where:_____

Have you been treated with allergy shots? __Yes __No If yes, for how long and when did you stop? _____

_____