Allergy History Form

Patient Name: _____ Date of Visit: _____

Date of Birth: _____ Sex: Male / Female

Primary Doctor: _____requested consultation for: _____
_____

Please answer all the questions that pertain to you:

The reason for your visit: _____

Allergies _____Asthma _____Sinusitis _____Drug Reactions _____Food Allergies _____

Insect sting reactions Skin rash _____Hives _____Contact Dermatitis _____

Immune deficiency _____ Others _____

How long have you had the problem: _____

Check all your current symptoms:
Eyes: Itching _____Redness _____Discharge _____Color of the discharge _____
Nose: Itching _____Redness _____Discharge _____Color of the discharge _____
Nasal congestion _____
Other symptoms:
Headache _____Sinus pain _____Cough _____ Daytime / Nighttime
Do you cough during or after exercise: Yes / No
Sneezing _____Snoring _____ Loss of smell _____ Bad breath _____ Sore throat _____
Drainage in the throat _____Color of the drainage _____Tiredness _____
Symptoms present throughout the year _____ Only some seasons: Spring / Summer / Fall / Winter

If you have ***asthma***, please answer the following questions:
Wheezing _____ Chest tightness _____Chest congestion _____Shortness of breath _____
Present in the morning _____ Every morning / 3 times a week / once a week / once a month
Symptoms present throughout the year _____ Only some seasons: Spring / Summer / Fall / Winter
How often do you see your doctor for asthma: Every month / 3 months / 6 months / rarely
How many times were you admitted to the hospital with asthma in the past year _____
Were you ever admitted in the ICU? _____ How many times? _____
What triggers your asthma? Infection / Cold air / Humidity / Allergens / Tobacco smoke / Others _____

If you have ***skin rash or hives***, please answer the following questions:
How long have you had this rash _____Does it look like Eczema _____ Hives _____
Where is the rash located: Face _____ Arms _____ Legs _____ All over the body _____ Other _____
Is it related to: Food intake _____Drug intake _____ Infection _____Contactant _____ Exercise _____
Exposure to cold _____ Exposure to heat _____ Do you have joint pain or swelling _____ For how long _____

If you have ***frequent infections,*** please answer the following questions:
Location of the infection: Sinuses _____Eyes, ears _____Bronchitis _____ Pneumonia _____
Skin _____ Other _____
How often have you had these infections: #___ times / month #_____ times / year
How long have you had frequent infections: Number of months _____ Number of years _____
Any deaths in family members from severe infections: _____

Past Medical History: What are your other medical problems? (Please circle)

Hypertension/Angina/Heart attack/Arrhythmias	Emphysema/Pneumonia
Stroke/Epilepsy/Migraine	Gastritis/Peptic ulcer/GE reflux/Hiatal Hernia
Diabetes/Hypothyroidism	Prostate problems

Name:_____**DOB:**_____**DOV:**_____

Cancer: _____
Others: _____

Past Surgeries: Tonsillectomy/Adenoidectomy/Sinus surgery/Nasal septoplasty/Ear tubes: Left/Right
Others: _____

Current Medications/Inhalers/Nebulizers:

Name	Dose	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies:

	Name	Reaction	How Long Ago
Medication:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Food:	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Insect Sting:	_____	_____	_____
	_____	_____	_____

Environmental History:

What type of house: Individual unit/Apartment New/Relatively new/Old/Very old
Do you have a basement: Yes/No Is it Damp or Dry? Do you use a De-humidifier: Yes/No
Heating system: Forced air/Radiators/Room heaters/Fireplace
Air conditioning: Central/Window units
How often do you change the filters on your furnace: Every month/3 months/6 months/never
Type of floors: Living area: Carpet/Wood/Vinyl/Other:_____
Bedroom: Carpet/Wood/Vinyl/Other:_____
Type of bed: Waterbed/Regular
How do you clean your furniture: Dusting/Wet mopping
Do you have any feather filled pillows or comforters: Yes/No
Do you have any stuffed toys: Yes/No Few/Many Are they in the bedroom: Yes/No
Do you have any pets: Dogs____Outdoor/Indoor Comes into your bedroom: Yes/No
Cats_____Outdoor/Indoor Comes into your bedroom: Yes/No
Birds____Outdoor/Indoor Comes into your bedroom: Yes/No
Others:_____
Do you bathe your pets? Yes/No If yes, how often:_____

Do you smoke: Yes/No How long_____ In home_____In car_____At work
Are you exposed to passive smoking: Yes/No In home_____In car_____At work
What is your current occupation? _____
Occupational exposures: _____

Review of symptoms: (Please circle each symptom that you have):
GENERAL: Fatigue, Anemia, Fainting, Night sweats, Low grade fever, Dizziness _____

Name:_____**DOB:**_____**DOV:**_____

HEENT: Frequent colds, Hoarseness, Tonsillitis, Swollen glands, Blurred vision, Ear Infections, Nose bleeds
ENDOCRINE: Thyroid problems, Diabetes, Adrenal gland problem _____
CVS: Chest pain, Palpitations, Edema of the legs, Night Cough, Irregular heart beats _____
PULMONARY: Shortness of breath, Difficulty breathing, Chest tightness, Coughing, Wheezing, Coughing up blood
GI: Heartburn, Nausea, Vomiting, Abdominal pain, Diarrhea _____
GU: Urinary tract infection, Bladder/Kidney infection _____
CNS: Migraine headache, Seizure, Numbness, Tingling _____
MUSCULOSKETAL: Arthritis, Joint swelling, Back pain _____
SKIN: Easy bruising, Skin infections, Hives, Eczema _____
GYN:_____

Family History:
Asthma: _____
Allergies: _____
Autoimmune disease: _____
Immunizations – are you updated on the following:
Routing Childhood Immunizations_____Flu Vaccination_____Pneumococcal Vaccination_____
Others _____
Past Allergy Workup:
Skin tests _____Date of last skin test _____
Skin tests were positive to _____
Past immunotherapy _____Antigens _____
Duration _____Adverse effects _____Improvement _____
PFTs: _____
Chest x-ray: _____
CT scans: Sinus: _____Other: _____
Other studies: _____
(Please bring all your previous CT scans, X-ray films, and lab results)