

**ALLERGY HISTORY**

Physician's Office: \_\_\_\_\_  
Patient Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Date: \_\_\_\_\_  
Sex: \_\_\_\_\_ Age: \_\_\_\_\_ DOB: \_\_\_\_\_

**To be filled out by patient,** It is important to check ( ✓ ) each question as accurately as possible. Your answers to the following comprehensive allergy questionnaire will help your physician to determine the cause of, and assist in the management of, your health care needs. Please take the time to fully and accurately fill out this form, as the following information is very important to your health!

Describe what symptoms bother you most. List problems in order of importance.	When did your problems begin?	What time of year (months) do your problems occur?
1 _____	1 _____	1 _____
2 _____	2 _____	2 _____
3 _____	3 _____	3 _____

	Yes	No	Don't Know
<b>Have trouble with your skin?</b>			
Eczema			
Hives			

	Yes	No	Don't Know
<b>Have trouble with your ears?</b>			
Popping			
Itching			
Hearing loss			
Fluid in ears			
Infection/Pain			

	Yes	No	Don't Know
<b>Have trouble with your throat?</b>			
Soreness			
Drainage			
Itching throat/mouth			
Swallowing difficulty			

	Yes	No	Don't Know
<b>Have trouble with your eyes?</b>			
Redness			
Itching			
Tearing			
Puffiness			
Dark circles			

	Yes	No	Don't Know
<b>Have trouble with your nose?</b>			
Clear/colorless discharge			
Thick/colored discharge			
Nasal itching/rubbing			
Constant stuffiness			
Periodic stuffiness			
Sniffles			
Sneezing			
Mouth breathing or snoring			

	Yes	No	Don't Know
<b>Have problems with your chest?</b>			
Wheezing with colds			
Wheezing when exposed to environmental allergies (dust, pollen, animal, etc.)			
Wheeze/cough after exercise			
Cough, what kind?			
Deep or productive			
Loose			
Constant			
Dry/tight			
Daytime			
Nighttime			

<b>Are your symptoms :</b>	Yes	No	Don't Know
Mild			
Moderate			
Severe			
Present most of the time			
Present part of the time			
Present rarely			
Interfering with your life			
Prevents normal activity			
Interferes with sleep			

<b>Are your symptoms aggravated by:</b>	Yes	No	Don't Know
Indoor			
Outdoor			
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			
Mowing lawn			
Dusty environment			
Animals			
Cooking odors			
Smoke			
Soap powder			
Paint fumes			
Perfumes/cosmetics			
Hair perms			
Newspapers			
Wool			
Road dust			

Are your symptoms aggravated by:	Yes	No	Don't Know
Eggs			
Wheat products			
Nuts			
Chocolate			
Beer			
Wine			
Milk products			
Spring			
Summer			
Fall			
Winter			
Stuffed toys			
Infection			
Sleeping			
Laughing			
Exercising			
Emotional problems			
<b>List any other problems</b>			
_____			
_____			
_____			

Do you take medications daily or frequently?			
Aspirin			
Cortisone			
Birth Control Pills			
Nose drops/sprays			
<b>Other medications (list):</b>			
1. _____ 2. _____			
3. _____ 4. _____			
5. _____ 6. _____			

Do any of your blood relatives have allergies?			
Have you ever been tested for allergies?			
Received injections?			
What are you allergic to?			
_____			

Have you ever missed time from school or work due to allergies?

Is there anything else about your problem which you think might be important or unusual?

\_\_\_\_\_

\_\_\_\_\_

	Yes	No	Don't Know
Smokers in your home?			
Do you smoke?			
Cigarettes/ # Per Day			
Pipe/ # Per Day			
Cigars/ # Per Day			
Years smoked			
Year stopped smoking			

<b>Do you spend a good deal of time in activities?</b>			
Photography			
Carpentry			
Camping			
Sewing			
Gardening			
Painting			
Cooking			
<b>Sports (list):</b>			
_____			
<b>Other (list):</b>			
_____			

Place an **X** next to the animals that you have in your home, or **circle** the animals that you feel cause an increase in your symptoms.

Cat \_\_\_\_ Dog \_\_\_\_ Horse \_\_\_\_ Rabbit \_\_\_\_ Goat \_\_\_\_ Bird \_\_\_\_

Bird \_\_\_\_ Cattle \_\_\_\_ Chicken \_\_\_\_ Rodent \_\_\_\_ Guinea Pigs \_\_\_\_

Gerbils \_\_\_\_ Hamsters \_\_\_\_

Other \_\_\_\_\_

<b>Do you live:</b>			
In a house			
In an apartment			
In the city			
In the suburbs			

<b>Is your dwelling:</b>			
0-10 years old			
11-40 years old			
>40 years old			
Is your bedroom shared?			
Upper bunk			
Lower bunk			
Stuffed toys			
Dolls			
Hardwood floors			
Wall-to-wall carpet			
Area rug			
Rubber carpet pad			
Ozite carpet pad			

Are your symptoms aggravated by:	Yes	No	Don't Know
Synthetic carpet pad			
Is your blanket wool?			
Cotton			
Synthetic			
Feathers			
<b>Does your dwelling have a basement?</b>			
Is it damp?			
Is it Dry?			
Is it musty?			
Dirt floor?			
Cement?			
Recreation area?			
Do you sleep with a pillow?			
Is it dacron?			
Is it foam rubber?			
Is it feather?			
<b>Other</b> (describe): _____			

Is your mattress cotton?			
Feather?			
Foam rubber?			
Waterbed?			
<b>Other</b> (describe): _____			

Do you use a humidifier?			
Do you have an air conditioner?			
<b>At work?</b>			
At home?			
In the bedroom?			
Central?			
Is your heating system oil?			
Gas?			
Coal?			
Electric?			
<b>Other</b> (describe): _____			

Is heat delivered by a blower?			
Radiators?			
Electric panels?			
<b>Other</b> (describe): _____			

<b>Bee Stings</b>			
When did the sting occur? _____			
What type of reaction did you have? _____			
Was a stinger present? _____ Did you go to the emergency room? _____			
Do you have an EpiPen, Anakit, or Twinject? _____			
Do you know how to use it? _____			
<b>Have you or a member of your family had</b> (indicate "F" for family):			
High blood pressure?			
Migraine headaches?			
Skin disease?			
Heart disease?			
Frequent headaches?			
Sinus disease?			
Cystic fibrosis?			
Asthma?			
Diabetes?			

Have you or a family member had:	Yes	No	Don't Know
Nasal polyps?			
Emphysema?			
Thyroid trouble?			
Bronchitis?			
Hay fever?			
Heartburn?			
Hormonal difficulty?			
Hives?			
Food allergy?			

**Drug Allergy** (describe):  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Hospital admissions?** (describe)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you think your occupation has anything to do with your symptoms?	Yes	No	Don't Know

**Describe your occupation:**  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Are there 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?	

**For patients under 12 years of age**

Birth Weight _____	Weight at 1 year _____
Present weight _____	Present height _____
Walked at _____	Toilet trained at _____

Breast fed			
Bottle fed			
Spitting up			
Colic			
Vomiting			
Croup			
Frequent colds			
Sinus trouble			
Earaches/infections			
Tonsilitis			
Bronchitis			
Pleurisy			
Pneumonia			
Headaches			
Eczema			
Cradle cap			
Many formula changes			
What formula(s)? _____			