Allergy History

Patient's Name ______________________ Home Phone #: ______________

Work Phone #: ______________

This form may be completed online and printed or saved. Simply click in the Yes or No field of each question.

	Y	N		Y	N		Y	N
Have trouble with your skin?			Have trouble with your throat?			Have trouble with your ears?		
Eczema			Frequently sore			Popping		
Hives			Itching throat/mouth			Itching		
Have trouble with our nose?			Have trouble with your eyes?			Do you have trouble with your chest?		
Clear/colorless discharge?			Redness			Wheeze/cough		
Thick/colored discharge?			Itching			Cough? What kind?		
Nasal itching/rubbing			Tearing			Deep/ productive		
Constant stuffiness			Puffiness			Loose		
Periodic stuffiness						Constant		
Sneezing						Daytime		
Mouth breathing/snoring						Nighttime		
Are your symptoms mild?			Smokers in the house?			Do you live in a house?		
Severe			Do you smoke?			Apartment		
Moderate						Is your dwelling new		
						How old		
Do you sleep with a pillow			Is your mattress cotton?			Do you use a humidifier?		
Is it Dacron			Less than 25 yrs old			Do you have AC		
Is it foam rubber						At work		
Is it feather						At home		
Other (describe)								
			Is your heating system …			Do you have animals in your home?		
Family history of:			Gas			Cat		
High blood pressure			Coal			Dog		
Migraine headaches			Electric			Other		
Skin disease			Other					
Heart disease								
Frequent headaches								
Sinus disease								
Stomach disease								
Asthma								
Nasal Polyps								
Emphysema								
Overactive thyroid								
Which of the following do you think cause your symptoms or make them worse?			Which of the following do you think cause your symptoms or make them worse?			Which of the following do you think cause your symptoms or make them worse?		
Indoors			Newspapers			Beer		
Outdoors			Milk or milk products			Wine		
At home			Eggs			Chemicals: (list)		
At work			Wheat products					
Morning			Chocolate					
Afternoon			Fish			Drugs: (list)		
At night			Meat					
Dusty environment			Alcoholic beverages					
Animals			Cheese, mushrooms					
Fruit			Vegetables					
What months do you have symptoms? (list)			Do you take medications daily or frequently? (list)			Do you spend a good deal of time in activities? (list)		

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Have you had any of the following?			Describe what symptom bothers you most?		Any additional information
High blood pressure					
Migrane headaches					
Skin disease					
Heart disease			When did your condition begin?		
Frequent headaches					
Sinus disease					
Stomach disease			Do you take medicine for nasal symptoms?		
Asthma					
Nasal polyps			What medication?		
Emphysema			Does it help?		
Overactive thyroid			Do any of your blood relatives have allergies?		
Bronchitis			Have you had skin tests for allergies?		
Nasal surgery					
Underactive thyroid					
Hay fever					
Deviated septum					
Hormonal difficulty					
Hives					
Food allergy					
Drug allergy (describe)					
Other conditions (describe)					
Are you taking medication for any of the previous conditions? (describe)					