PATIENT HISTORY FORM

Patient's Name: _____ Today's Date: _____

Please complete this allergy information list by circling or underlining applicable conditions.

Current complaint/symptoms: _____

_____

EYES: itching burning tearing swelling redness discharge

EARS: itching fullness popping frequent infections draining
Tubes? ❑ Yes ❑ No If Yes, Date: _____

NOSE: itching blocked sneezing running nosebleeds snoring mouth breathing decreased smell
frequents colds polyps (Date of last sinus CT scan: _____)

THROAT: sore mucous post-nasal discharge itching hoarseness
Tonsil & Adenoid Removal? ❑ Yes ❑ No If Yes, Date: _____

CHEST: cough wheeze pain tightness sputum (color _____ amount _____)
shortness of breath: at rest after exertion (Date of last chest x-ray: _____)

SKIN: rash eczema hives swelling itching dry

G-I: nausea cramping gas diarrhea vomiting weight loss difficulty swallowing heartburn

HEAD: headache dizziness lightheaded pressure vertigo

GENERAL: fatigue fever tension sweats chills insomnia

PAST HISTORY: asthma hay fever eczema hives insect allergy sinus infections pneumonia ear infections bronchitis croup
Please list all known food, drug and animal allergies:

_____

Previous allergy medications including OTC medications? ❑ Yes ❑ No
If Yes, Drug names & Dates of use: _____
Previous treatment by an allergist? ❑ Yes ❑ No
If Yes, Dates _____ Dr. _____ Address _____
Previous allergy injections? ❑ Yes ❑ No
If Yes, Dates _____ Dr. _____ Address _____
Past major illnesses & Dates: _____
Past major hospitalizations & Dates: _____
Current medications: Please list **all** current medications including OTC medications

_____

When do symptoms occur?: spring summer fall winter morning night day indoors outdoors
exertion weather change emotions old-leaves hay lakeside barns summer home basement attic
lawn-mowing animals alcohol air conditioning heat dampness/humidity cold
perfumes chemicals paints hairspray tobacco ozone insecticides newsprint cosmetics latex

Do you smoke? ❑ Yes ❑ No **Are you exposed to smokers?** ❑ Yes ❑ No

Do symptoms occur after eating? ❑ Yes ❑ No If Yes, please list all known or suspected foods:

_____

FAMILY HISTORY: Any family members with allergies or asthma? ❑ Yes ❑ No If Yes, please indicate.
❑ Father ❑ Mother ❑ Sister(s) ❑ Brother(s) ❑ Grandparent(s)

ENVIRONMENT: Occupation _____ List work exposures, if any _____
Recreation & hobby exposure list _____
Pets/Animals: ❑ Dog(s) ❑ Cat(s) ❑ Bird(s) ❑ Other(s) _____
Bedroom exposures: quilts comforters drapes blinds wall hangings books stuffed animals shutters
air conditioner humidifier air cleaner
Pillow: ❑ Synthetic ❑ Feather Carpet in Bedroom? ❑ Yes ❑ No
Bedroom heat type: Forced Air / Baseboard / Radiator Any stuffed bedroom furniture? ❑ Yes ❑ No

(SIDE 2)

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FOR OFFICE USE ONLY: Reviewed by _____ Date _____