PATIENT HISTORY FORM

Patient's Name:	Today's Date:

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

Current complaints/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 frequent 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

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 the 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