

# ALLERGY HISTORY

Name: \_\_\_\_\_

Date \_\_\_\_\_

## WHICH SYMPTOMS HAVE YOU EXPERIENCED?

- |  |  |   |  |
|--|--|---|--|
| <input type="checkbox"/> Hay Fever       | <input type="checkbox"/> Cough               | <input type="checkbox"/> Headache         | <input type="checkbox"/> Colitis         |
| <input type="checkbox"/> Runny Nose      | <input type="checkbox"/> Cough at Night      | <input type="checkbox"/> Diarrhea         | <input type="checkbox"/> Mental Dullness |
| <input type="checkbox"/> Stuffy Nose     | <input type="checkbox"/> Wheezing            | <input type="checkbox"/> Constipation     | <input type="checkbox"/> Nausea          |
| <input type="checkbox"/> Sinus Problems  | <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Stomach Problems | <input type="checkbox"/> Fatigue         |
| <input type="checkbox"/> Itching Eyes    | <input type="checkbox"/> Tight Chest         | <input type="checkbox"/> Hives            | <input type="checkbox"/> Sleep Problems  |
| <input type="checkbox"/> Post Nasal Drip | <input type="checkbox"/> Exercise Problems   | <input type="checkbox"/> Severe Acne      | <input type="checkbox"/> Mood Changes    |
| <input type="checkbox"/> Sneezing        |  | <input type="checkbox"/> Eczema           |  |
| <input type="checkbox"/> Arthritis       |  | <input type="checkbox"/> Rashes           |  |
| <input type="checkbox"/> Asthma          |  |   |  |

### Known Allergies: \_\_\_\_\_

How long have you had these symptoms: \_\_\_\_\_

0-1 yrs     1-5 yrs     5-10 yrs     10+ yrs

What time of year do you have these symptoms? \_\_\_\_\_

Jan    Feb    Mar    Apr    May    Jun  
Jul    Aug    Sept    Oct    Nov    Dec    All Year

What do you think you are allergic to? \_\_\_\_\_

Are your allergies worse when you are outside \_\_\_\_\_

Yes     No

Have you been evaluated for allergies before? \_\_\_\_\_

Yes     No    When? \_\_\_\_\_

Where? \_\_\_\_\_

Do you receive allergy shots?     Yes     No

Is there a family history of allergies or asthma? \_\_\_\_\_

Mother     Father     Siblings     Other

Do you have frequent sinus infections? \_\_\_\_\_

Yes     No

How many per year? \_\_\_\_\_

Are you exposed to smoke? \_\_\_\_\_

Yes     No

Do you smoke?     Yes     No    How much? \_\_\_\_\_

How long? \_\_\_\_\_

Who is your family Physician? \_\_\_\_\_

Current Medications? \_\_\_\_\_

Are you allergic to any medications? \_\_\_\_\_

Yes     No

What? \_\_\_\_\_

### HOME

#### ENVIRONMENT:

How long have you lived in the Tri-Cities? \_\_\_\_\_

How long in your present home? \_\_\_\_\_

Type of home? \_\_\_\_\_

Age of home? \_\_\_\_\_

Carpeting? \_\_\_\_\_

Is there Water/Mildew damage? \_\_\_\_\_

Heating/Cooling

Central

Floor Furnace

Wood Stove

Window A/c

Filters

Other

Do you have pets? \_\_\_\_\_

Cat

Dog

Other

### WORK

#### ENVIRONMENT:

Occupation: \_\_\_\_\_

Do symptoms get worse at work? \_\_\_\_\_

Toxic Exposure: \_\_\_\_\_

Solvents

Chemicals

Fumes

Dust

Mildew