ALLERGY HISTORY FORM

Patient Name: _____ Date of Birth _____

Symptom	Yes	No	Don't Know
Any skin problem?	____	____	____
Hives	____	____	____
Eczema	____	____	____
Any ear problems?	____	____	____
Popping	____	____	____
Itching	____	____	____
Hearing loss	____	____	____
Fluid in ears	____	____	____
Infection/pain	____	____	____
Any trouble with throat?	____	____	____
Post nasal discharge	____	____	____
Itching in throat	____	____	____
Any trouble with eyes?	____	____	____
Redness	____	____	____
Itching	____	____	____
Tearing	____	____	____
Puffiness	____	____	____
Any Nose or sinus problem?	____	____	____
Clear drainage	____	____	____
Thick colored drainage	____	____	____
Nasal itching and rubbing	____	____	____
Constant stuffiness	____	____	____
Sniffles	____	____	____
Sneezing	____	____	____
Mouth breathing or snoring	____	____	____
Any trouble with chest?	____	____	____
Wheezing with colds	____	____	____
Wheezing when exposed to dust, pollen, etc.	____	____	____
Wheezing after exercise	____	____	____
Cough? What kind?	____	____	____
Deep/productive	____	____	____
Dry	____	____	____
Constant	____	____	____
Day time	____	____	____
Night time	____	____	____
During what months are your symptoms present?			
All months	____	____	____
Spring	____	____	____
Summer	____	____	____
Fall	____	____	____
Winter	____	____	____
When did your condition begin?	_____		
Do you use any allergy medication?	_____		
What medication?	_____		
Does it help?	_____		
Does any of your blood relatives have allergies?	_____		
Are your symptoms mild?	____	____	____
Moderate	____	____	____
Severe	____	____	____
Present most of the time	____	____	____
Present part of the time	____	____	____
Present rarely	____	____	____
Interfering with your life	____	____	____

What triggers your symptoms or make them worse?			
Indoors	____	____	____
Outdoors	____	____	____
At home	____	____	____
At work	____	____	____
Morning	____	____	____
Afternoon	____	____	____
At night	____	____	____
Which of the following weather conditions triggers your symptoms or makes them worse?			
Wet weather	____		
Dry weather	____		
Windy day	____		
Hot day	____		
Cold day	____		
Air conditioning	____		
Which of the following triggers your symptoms or makes them worse?			
Mowing lawn	____		
Dusty environment	____		
High air pollution	____		
Animals	____		
Smoke	____		
Perfumes / cosmetics	____		
Milk / milk products	____		
Eggs	____		
Wheat products	____		
Nuts, beans, seeds	____		
Chocolate	____		
Fish	____		
Meat	____		
Fruit	____		
Alcohol	____		
Aspirin	____		
Chemicals (list)	_____		
	_____		

	YES	NO	Don't Know
Does your home have			
Carpet / rug	____	____	____
Wood / tile floor	____	____	____
Indoor plants	____	____	____
Mildew under sink, washer, refrigerator	____	____	____
Smokers in your home?	____	____	____
Do you smoke?	____	____	____
Any pets at home?	____	____	____
If yes, list:	_____		