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Dear Patient,

Allergy evaluation consists of mainly three parts — History, Physical Examination, Skin Testing, sometimes Lab Work. The most important part is History. That is why we ask you to please fill out the enclosed forms. I know it is lengthy, but it helps us to evaluate your condition more thoroughly.

Patient Name ______________________________ Date of Birth: ______________

Your first visit with the allergist will include a detailed history of your problem, followed by a physical examination, and perhaps allergy testing. During the history, you and the doctor will discuss:

- the chief problem which brings you to the allergist
- details of this chief problem, including its duration, specific symptoms, and pattern
- medications used for this problem, and their effect
- factors, if any, which you recognize as worsening the symptoms
- other allergy problems, past or present, in addition to the current main problem
- any non-allergy medical problems, past or present, including any current non-allergy medications
- your dietary, cigarette, and alcohol habits
- your family history of allergy and other medical problems
- details of your home and other environmental exposures

An accurate history is essential for proper diagnosis and treatment.
Please fill out this information ***before*** *your visit, so that you can use your time with the doctor to your best advantage.*

Part One - Health History

1. What chief problem(s) bring you to the allergist at this time?

____

____

____

____

2. If your problem is with the nose, ears or eyes, does it include:

- ❑ sneezing
- ❑ watery nasal discharge
- ❑ discolored discharge
- ❑ post-nasal drip
- ❑ nasal itch
- ❑ nasal blockage
- ❑ loss of smell
- ❑ mouth breathing
- ❑ snoring
- ❑ sinus pressure
- ❑ nose bleeds
- ❑ headache
- ❑ sinus infections needing antibiotic (_____ per year)
- ❑ ear infections needing antibiotic (_____ per year)
- ❑ loss of hearing
- ❑ itching of ears
- ❑ redness of eyes
- ❑ itching of eyes
- ❑ swelling of eyelids
- ❑ tearing
- ❑ ________________
- ❑ ________________

3. If your problem is with the chest, does it include:

- ❑ coughing
- ❑ wheezing you can hear
- ❑ wheezing heard by MD
- ❑ tightness in chest
- ❑ shortness of breath
- ❑ awakening at night
- ❑ chest pain
- ❑ repeated episodes of bronchitis needing antibiotics (_____ per year)
- ❑ decreased exercise capacity
- ❑ asthma attack(s) requiring emergency treatment
- ❑ asthma attack(s) requiring overnight hospitalization

4. If your problem is with the skin, does it include:

- ❑ hives
- ❑ eczema
- ❑ dryness
- ❑ redness
- ❑ itching

5. If your problem is related to an insect sting, did you experience:

- ☐ swelling at the site of the sting only
- ☐ hives over the entire body
- ☐ swelling away from the site of the sting
- ☐ dizziness or faintness
- ☐ loss of consciousness
- ☐ wheezing
- ☐ fullness of throat or difficulty swallowing
- ☐ nausea or vomiting ?

6. Duration and pattern:

- ☐ symptoms have been present for _____ weeks / months / years
- ☐ spring
- ☐ summer
- ☐ fall
- ☐ winter
- ☐ year round at constant level
- ☐ year round but worse during season(s) checked

7. Severity:

- ☐ mild
- ☐ moderate
- ☐ severe
- ☐ interfere with sleep
- ☐ interfere with physical exertion
- ☐ interfere with school or work

8. Please list all prescription and non-prescription medications (*including inhalers, nose sprays, eye drops, and lotions*) that have been used to treat these symptoms:

☐_______________ was it effective? __________any side effects?____________
☐_______________ was it effective? __________any side effects?____________
☐_______________ was it effective? __________any side effects?____________
☐_______________ was it effective? __________any side effects?____________
☐_______________ was it effective? __________any side effects?____________
☐ previous allergy testing?________ when?_______ ☐ previous allergy injections?______ when?_________

9. Please mark those exposures that you know make you feel worse:

- ☐ exposure to house dust
- ☐ cleaning house
- ☐ exposure to basements
- ☐ moldy smells
- ☐ raking leaves
- ☐ playing in leaves
- ☐ exposure to compost
- ☐ cats
- ☐ dogs
- ☐ horses
- ☐ birds
- ☐ other animals___________
- ☐ cut grass
- ☐ plants
- ☐ gardening
- ☐ change in barometric pressure
- ☐ change in temperature
- ☐ humidity
- ☐ wind
- ☐ cold air
- ☐ heat
- ☐ rain
- ☐ night time
- ☐ morning
- ☐ meals
- ☐ recumbency
- ☐ menstrual cycle
- ☐ physical exertion
- ☐ exercise
- ☐ emotional stress
- ☐ laughter
- ☐ work
- ☐ home
- ☐ school
- ☐ other location___________
- ☐ cigarette smoke
- ☐ strong odors
- ☐ perfumes
- ☐ air pollution
- ☐ chlorinated pool
- ☐ alcohol
- ☐ foods________________ ________________
- ☐________________
- ☐________________
- ☐________________

10. In addition to the main problem(s) discussed above, have you had <u>other</u> allergy symptoms at any time?

- ☐ infancy or early childhood_______________________________________
- ☐ food allergies

food _______________ how did you react ?______________________
food _______________ how did you react ?______________________
food _______________ how did you react ?______________________
food _______________ how did you react ?______________________

- ☐ medication allergies

penicillin?____________ how did you react ?______________________

aspirin, Advil, etc. ___________ how did you react ?______________________________
other______________________ how did you react ?______________________________
other______________________ how did you react ?______________________________
other______________________ how did you react ?______________________________

☐ allergy to dye injected for X-ray ____
☐ allergy to latex or rubber ____

Patient's Name ________________________________

☐ hives ____
☐ impressive swelling of lips, tongue, or throat ________________________________

☐ nasal drip or blockage ____
☐ snoring, mouth breathing or sleep apnea ___________________________________

☐ asthma, wheezing or shortness of breath____________________________________

☐ repeated ear infections requiring antibiotic (____ per year)
☐ repeated sinus infections requiring antibiotic (____ per year)
☐ repeated throat infections requiring antibiotic (____ per year)
☐ repeated bronchial infections requiring antibiotic (____ per year)

☐ insect sting allergy *more than* large swelling at site of sting ____________________

☐ eczema
☐ poison ivy or other contact allergy

11. Please list any non-allergy medical problems that you now have, and the medicines being used to treat them. Please include eye drops, vitamins, supplements and over the counter medications you may take.

☐ high blood pressure medication ______________________________
☐ heart disease medication ______________________________
☐ elevated cholesterol medication ______________________________
☐ ulcers medication ______________________________
☐ heartburn or reflux medication ______________________________
☐ thyroid disease medication ______________________________
☐ prostate or urinary medication ______________________________
☐ glaucoma medication ______________________________
☐ depression medication ______________________________
☐ ______________ medication ______________________________
☐ ______________ medication ______________________________
☐ ______________ medication ______________________________
☐ ______________ medication ______________________________

12. Please list any previous medical problems, including hospitalizations and surgery:

☐ ____
☐ ____
☐ ____
☐ ____

13. If you are a woman, are you

☐ taking birth control pills?
☐ pregnant?

☐ planning to become pregnant? if so, when __________
☐ breast feeding?

14. Have you had recent X-rays?

☐ chest approximate date_________ result_________________
☐ sinus x-ray approximate date_________ result_________________
☐ sinus CAT scan approximate date_________ result_________________

15. Please describe your social habits:

☐ cigarettes _______pack per day ☐ former smoker, quit ___________
☐ alcohol _____drinks per ______ ☐ former drinker, stopped_________
☐ coffee ______cups per day
☐ "recreational" drugs__________________
☐ dietary habits__________________ ☐ intake of milk and milk products__________________
☐ travel out of US ____
☐ are you under any unusual emotional stress due to home, family or work?_________________________
____

16. Please list allergies and major non-allergic illnesses in family members:

☐ patient's father ____
☐ patient's mother ____
☐ patient's brother(s)____
☐ patient's sisters(s) ____
☐ patient's children ____
☐ patient's grandparents ____
☐ patient's cousins, aunts, uncles ____

Social History

Primary Residence for the patient is:

[ ] One Home
[ ] Split between homes

Current occupation is: ______________________________
Occupational exposures: ______________________________
____

Smoking: Y [ ] N [ ] If yes, years____ packs/day____

Use of Recreational Drugs
Smoked_______ Intranasal_______ Other________

Drink Alcohol? Y [ ] N [ ]
Number of drinks per day_____
Other relevant social factors:___________________________
____

Review of Systems: (check if present)

- ☐ Fever
- ☐ Weight loss
- ☐ Skin problems besides eczema
- ☐ Joint swelling or pain
- ☐ Blood count problems (anemia, ect.)
- ☐ Eye problems
- ☐ Throat infections
- ☐ Heart problems, high blood pressure or palpitation
- ☐ Stomach upset
- ☐ Urinary or bladder problems
- ☐ Nerve or psychiatric problems
- ☐ Hormone problems (such as hot flashes, etc.)

Other Comments:

____
____

Name of person filling out this history form (please print): ______________________________
Relationship if not the patient: ______________________________

Patient's Name____________________________

Part Two—Environmental History

46

Type of home

- ☐ private house
- ☐ condominium
- ☐ apartment in apt. building
- ☐ apartment in house
- ☐ dormitory

Type of area

47

- ☐ residential
- ☐ wooded
- ☐ farmland
- ☐ urban
- ☐ near lake or pond
- ☐ near highway or factory

Basement

- ☐ finished
- ☐ unfinished
- ☐ none
- ☐ damp and musty
- ☐ dirt cellar

Humidification

48

- ☐ none
- ☐ de-humidifier
- ☐ room humidifier
- ☐ central humidifier

Heating

- ☐ baseboard hot water
- ☐ radiator hot water
- ☐ forced hot air
- ☐ electric baseboard
- ☐ wood stove

Supplementary Heating

49

- ☐ none
- ☐ wood stove
- ☐ kerosene heater
- ☐ fireplace

Cooling

- ☐ none
- ☐ room air conditioning, including patient's room
- ☐ room air conditioning, not in patient's room
- ☐ central air conditioning
- ☐ whole-house attic fan
- ☐ window fans

Air cleaners

50

- ☐ none
- ☐ central
- ☐ room air cleaner, "HEPA"
- ☐ room air cleaner, not "HEPA"

Stove

51

- ☐ electric
- ☐ gas, with pilot light
- ☐ gas, without pilot light

Bedroom floor

52

- ☐ wall-to-wall carpet over plywood sub-floor
- ☐ wall-to-wall carpet over hardwood floor
- ☐ hardwood floor
- ☐ hardwood floor with large area rug
- ☐ hardwood floor with small area rug
- ☐ tile
- ☐ linoleum

Bed

- ☐ standard bed

Mattress

53

- ☐ standard innerspring

☐ water bed
☐ padded water bed
☐ bunk bed, patient on top
☐ bunk bed, patient on bottom
☐ canopy bed
☐ crib

☐ foam
☐ futon
☐ waterbed
☐ horsehair
☐ encased in dust-proof cover
☐ crib mattress

Pillow

☐ dacron / polyester
☐ down / feathers
☐ foam
☐ encased in dust-proof cover
☐ none

Blankets

54

☐ synthetic
☐ cotton
☐ electric
☐ wool
☐ down / feathers
☐ comforter

Other items in bedroom

☐ none
☐ few stuffed toys
☐ many stuffed toys
☐ upholstered chair
☐ wall hangings
☐ curtains
☐ pennants
☐ plants

Bedroom shared

55

☐ no
☐ with one sibling
☐ with two or more siblings
☐ with spouse
☐ with significant other

Cats

56

☐ none
☐ one
☐ two
☐ three
☐ four or more

☐ run of house
☐ sleep on patient's bed
☐ kept out of patient's bedroom
☐ outside in warm weather
☐ outside only

☐ present for 1 year
☐ present for 2 years
☐ present for 3 years
☐ present for 4 years
☐ present for 5 or more years

Dogs

57

☐ none
☐ one
☐ two
☐ three
☐ four or more

☐ run of house
☐ sleep on patient's bed
☐ kept out of patient's bedroom
☐ outside in warm weather
☐ outside only

☐ present for 1 year
☐ present for 2 years
☐ present for 3 years
☐ present for 4 years
☐ present for 5 or more years

Other animals

58

☐ none
☐ bird
☐ horse

☐ rabbit
☐ guinea pig
☐ hamster

☐ gerbil
☐ mouse
☐ ferret

☐ cattle
☐ ____________
☐ ____________

Pests

59

☐ cockroaches
☐ ladybugs
☐ mice

Secondary cigarette exposure

☐ none
☐ father
☐ father, but not indoors
☐ mother
☐ mother, but not indoors

Hobbies

60

☐ gardening
☐ woodworking
☐ exercise
☐ sports
☐ music

- ☐ both parents
- ☐ spouse or significant other
- ☐ work

- ☐ dance
- ☐ ____________
- ☐ ____________

Chemical exposures

- ☐ none
- ☐ insecticides
- ☐ fabric softeners
- ☐ NCR paper
- ☐ photocopiers
- ☐ __________

Occupation

61

- ☐ homemaker
- ☐ student
- ☐ office worker
- ☐ factory worker
- ☐ teacher
- ☐ executive
- ☐ business owner
- ☐ child
- ☐ _________________

PAST MEDICAL HISTORY

Hospitilizations: Age or Year

_____ for ______________________________

_____ for ______________________________

_____ for ______________________________

Surgeries:

_____ for ______________________________

_____ for ______________________________

_____ for ______________________________

Emergency Visits:

_____ Times in past year

_____ Times in past five years

Drug Allergies: Symptoms:

________________ Caused ______________________________

________________ Caused ______________________________

________________ Caused ______________________________

Immunizations up to date for the age: Y[ ] N [ ]

Immunization Adverse Reactions:

________________ Caused ______________________________

Other Chronic Health Conditions: Age or Year

__________________________ Since ______

__________________________ Since ______

__________________________ Since ______

Notes:

Family History

	Allergies	Asthma	Freq. coughing	Freq. Infections
Father	☐	☐	☐	☐
Mother	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐
Grandfather(s)	☐	☐	☐	☐
Grandmother(s)	☐	☐	☐	☐
Uncle(s)	☐	☐	☐	☐
Aunt(s)	☐	☐	☐	☐
Cousin(s)	☐	☐	☐	☐

Other chronic conditions such as cystic fibrosis, emphysema, recurrent hives or swelling, lupus, rheumatoid arthritis, etc.;

Patient's Name: ______________________________

SYMPTOMS GET WORSE OR IMPROVE

Outdoors [ ] Indoors [ ] At work or school [ ]
All day [ ] Night or morning [ ]

Patient's Name: ______________________________

SYMPTOMS ARE MADE WORSE BY:

[ ] Colds/Infection	[ ] Cats/Dogs
[ ] Cigarette smoke	[ ] Weather changes
[ ] Mowing grass	[ ] Windy days
[ ] Raking leaves	[ ] Damp areas
[ ] Perfumes or scents	[ ] Heat
[ ] Dusting or cleaning	[ ] Cold
[ ] Food	[ ] Other

ALL CURRENT MEDICINES number mg, tab, caps, or inhaler puffs

____________________ __________ _______ Times per day

____________________ __________ _______ Times per day

____________________ __________ _______ Times per day

____________________ __________ _______ Times per day

____________________ __________ _______ Times per day

PREVIOUS ALLERGY OR ASTHMA MEDICATIONS(INCL. OTC):

________________ [ ] helped [ ] no help [ ] drowsy [ ] jittery
________________ [ ] helped [ ] no help [ ] drowsy [ ] jittery
________________ [ ] helped [ ] no help [ ] drowsy [ ] jittery

CURRENT ENVIRONMENT (X IF PRESENT):

Home/Apt ____________ Length of occupancy ___________
How old is the building? ________ Yrs

	Yes/No		Yes/No
Cats	☐ ☐	Baseboard Heat	☐ ☐
Dogs	☐ ☐	Forced air heat	☐ ☐
Birds	☐ ☐	Air conditioning	☐ ☐
Other pets	☐ ☐	Humidifier	☐ ☐
Feather pillows	☐ ☐	Lots of houseplants	☐ ☐
Down comforter	☐ ☐	Damp baseball	☐ ☐
Carpets or rugs	☐ ☐	Mold growth	☐ ☐
Air cleaner	☐ ☐	Roaches	☐ ☐
Cigarette smoke	☐ ☐	Improvements on trips	☐ ☐

PAST ALLERGY HISTORY: (Use space at right if needed)

	Yes/No
Previous allergy testing?	☐ ☐
If yes then answer the questions below:	
Testing done by Dr. ___________ in 19 __	
Previous allergy shots	☐ ☐
Still on allergy shots	☐ ☐
Shots are received every ____ week now	
Allergy shots helped	☐ ☐
Only minor reaction with the shots	☐ ☐
If major reactions then explain:	

____
____
____
____

PATIENT QUESTIONNAIRE

DO YOU HAVE ALLERGIES?
- ☐ Yes
- ☐ No
- ☐ Don't Know

What are you allergic to?

DO YOUR BLOOD RELATIVES HAVE ALLERGIES?
- ☐ Yes
- ☐ No
- ☐ Don't Know

NAME

WHAT MEDICATION DO YOU TAKE DAILY OR FREQUENTLY?
- ☐ Aspirin
- ☐ Vitamins
- ☐ Cortisone
- ☐ Ointments
- ☐ Laxatives
- ☐ Nose Drops
- ☐ Sedatives
- ☐ Hormones
- ☐ Birth Control Pills
- ☐ Other (list):

BY

DATE

CHECK ANY OF THE FOLLOWING MEDICAL CONDITIONS YOU HAVE OR HAD.
- ☐ High Blood Pressure
- ☐ Heart Disease
- ☐ Stomach or Intestinal Disease
- ☐ Overactive Thyroid
- ☐ Underactive Thyroid
- ☐ Any Hormonal Difficulty
- ☐ Migraine Headache
- ☐ Frequent Headaches
- ☐ Asthma
- ☐ Sinus Disease
- ☐ Emphysema
- ☐ Nasal Polyps
- ☐ Bronchitis
- ☐ Broken Nose
- ☐ Hay Fever
- ☐ Nasal Surgery
- ☐ Hives
- ☐ Deviated Septum
- ☐ Skin Disease
- ☐ Food Allergy
- ☐ Drug Allergy
  What drugs? ____________________
- ☐ Other Conditions

DO YOU USE MEDICATION REGULARLY FOR NASAL SYMPTOMS?
☐ Yes ☐ No

What is it?

Does it help?

NOTES

HEATING SYSTEM:
- ☐ None
- ☐ Electricity
- ☐ Oil
- ☐ Don't Know
- ☐ Gas
- ☐ Other
- ☐ Coal

METHOD OF HEAT DELIVERY:
- ☐ Hot Air Blower
- ☐ Radiators
- ☐ Electric Panels
- ☐ Don't Know

PILLOW:
- ☐ None Used
- ☐ Foam Rubber
- ☐ Feather
- ☐ Dacron
- ☐ Don't Know
- ☐ Other

MATTRESS:
- ☐ Cotton
- ☐ Foam Rubber
- ☐ Horse Hair
- ☐ Feather
- ☐ Don't Know
- ☐ Other

DO YOU USE HUMIDIFIERS?
☐ Yes ☐ No

CHECK SYMPTOMS YOU USUALLY HAVE:
- ☐ Itching of Nose
- ☐ Stuffy Nose
- ☐ Nose Running
- ☐ Sneezing
- ☐ Post-nasal Drip
- ☐ Loss of Smell
- ☐ Eyes Itch
- ☐ Eyes Water
- ☐ Throat Itch
- ☐ Ear Infection
- ☐ Sore Throat
- ☐ Cough
- ☐ Wheeze

HOME:
- ☐ House
- ☐ City
- ☐ Apt.
- ☐ Country

YOUR ENVIRONMENT:

OCCUPATION: ____________________

Prominent materials used:

At work, are your symptoms
☐ Better ☐ Worse ☐ Same

AIR-CONDITIONING:
- ☐ Bedroom
- ☐ At Work
- ☐ Central
- ☐ None

ANIMALS IN HOME:

IN PAST	AT PRESENT
☐ Dog	☐ Dog
☐ Cat	☐ Cat
☐ Bird	☐ Bird
☐ Rodent	☐ Rodent
☐ Other	☐ Other

Other animals you frequently contact:

ARE SYMPTOMS:
- ☐ Constant
- ☐ Erratic
- ☐ Present Most of Time
- ☐ Present Part of Time
- ☐ Present Rarely

DURING WHAT MONTHS DO YOU USUALLY HAVE SYMPTOMS?
- ☐ All months

☐ Jan. ☐ Apr. ☐ July ☐ Oct.
☐ Feb. ☐ May ☐ Aug. ☐ Nov.
☐ Mar. ☐ June ☐ Sep. ☐ Dec.

ARE SYMPTOMS WORSE:
- ☐ Morning
- ☐ Afternoon
- ☐ Evening
- ☐ Night
- ☐ At Home
- ☐ At Work
- ☐ Other Location

SMOKING HABITS:

Cigarettes #____/day

Pipe #____/day

Cigars #_____/day

Years Smoked: ____________

Stopped smoking in _______

ARE YOUR SYMPTOMS:
- ☐ Slight
- ☐ Moderate
- ☐ Severe

DO YOUR SYMPTOMS INTERFERE WITH YOUR LIFE?
- ☐ Not at All
- ☐ A Little
- ☐ Moderately
- ☐ Prevent Many Normal Activities

SOME OF THE FOLLOWING MAY CAUSE YOUR SYMPTOMS OR MAKE THEM WORSE. CHECK THOSE THAT DO.
- ☐ In-doors
- ☐ Out-doors
- ☐ Weather Change
- ☐ Wet Weather
- ☐ Dry Weather
- ☐ Windy Day
- ☐ Hot Day
- ☐ Cold Day
- ☐ Air-Conditioning
- ☐ In Barns
- ☐ Damp Areas
- ☐ Hay, Circus
- ☐ Mowing Lawn
- ☐ Dusty Environment
- ☐ High Pollution Day
- ☐ Animals
- ☐ Cooking Odors
- ☐ Smoke
- ☐ Soap Powder
- ☐ Insecticides
- ☐ Paint Fumes
- ☐ Perfumes
- ☐ Cosmetics
- ☐ Wave Sets
- ☐ Newspapers
- ☐ Wool
- ☐ Road Dust
- ☐ Chemicals (list)
- ☐ Milk or Milk Products
- ☐ Eggs
- ☐ Wheat Products
- ☐ Nuts, Beans, or Seeds
- ☐ Chocolate
- ☐ Fish
- ☐ Meat
- ☐ Fruit
- ☐ Vegetables
- ☐ Alcoholic Beverages
- ☐ Beer
- ☐ Wine
- ☐ Cheese, Mushrooms
- ☐ Aspirin
- ☐ Drugs (list)

ACTIVITIES IN WHICH YOU SPEND A GREAT DEAL OF TIME:

- ☐ Photography
- ☐ Gardening
- ☐ Camping
- ☐ Cooking
- ☐ Carpentry
- ☐ Painting
- ☐ Sewing
- ☐ Movies
- ☐ Hobbies List:
- ☐ Other List:
- ☐ Sports List:

Describe in your own words what bothers you the most:

Can you remember how the condition began and when?

USE THIS SPACE IF YOU WISH TO AMPLIFY ANY OF THE ABOVE ANSWERS

FAMILY HISTORY:

ASTHMA -

URTICARIA -

HAY FEVER -

ECZEMA -

HEADACHES (MIGRAINE) -

OTHER:

PHYSICIAN'S FINDINGS