Allergy History

Don't Panic! This won't take long and you know all the answers.

Patient's Name: First Last **DOB:** **Age:**

Were you referred by another doctor? ❑Yes ❑ No Name: _____

What **symptom(s)** is your primary concern?

Please check all recurrent symptoms. (Food symptoms next page)

Nasal Symptoms:	**Sinus Symptoms:**	**Chest/Throat Symptoms:**	**Skin Symptoms:**
❑ Runny nose	❑ Post nasal drainage	❑ Wheezing	❑ Itching
❑ Nasal congestion	❑ Frequent throat clearing	❑ Chest tightness	❑ Eczema
❑ Sneezing	❑ Sinus pressure	❑ Shortness of breath	❑ Hives
❑ Itchy eyes	❑ Headache	❑ Cough	❑ Swelling
❑ Watery eyes	❑ Colored nasal mucous	❑ Wheezing with exercise	❑ Blisters
❑ Itchy nose	❑ Stuffy ears	❑ Difficulty breathing at night	❑ Contact allergy
❑ Itchy ears	❑ Frequent sinus infections	❑ Frequent pneumonia	❑ Other
❑ Itchy throat	❑ Bad breath	❑ Throat tightness	_____
❑ Decreased taste or smell	❑ Snoring	❑ Hoarse voice	_____

How long have you had these symptoms?

Nasal _____ Sinus _____ Chest _____ Skin _____

How often do the symptoms occur? (constant, daily, weekly, monthly, off-and-on)

Nasal _____ Sinus _____ Chest _____ Skin _____

Is there any **seasonal variation** in your symptoms and if so, when are they worse? ❑Yes ❑ No

Nasal _____ Sinus _____ Chest _____ Skin _____

What **medications** have you tried for your allergy symptoms?

Helped No Help

What **environmental triggers** have made your symptoms worse? ❑Mowed grass ❑Windy weather ❑Dust
❑ Spending time out of doors ❑ Moldy places ❑ Sweeping or dusting ❑ Cigarette smoke ❑ Pollen ❑ Insect sting
❑ Exercise ❑ Respiratory infections ❑ Weather changes ❑ Laughing ❑ Cold Air ❑ Nighttime ❑ Stressful events
❑ Animals (specify) _____ ❑ Perfumes, cosmetics, odors, etc. (specify) _____

Have you had a **sinus CT**? ❑Yes ❑ No When? Results

Other physicians seen for this problem? ❑ ENT ❑ Pulmonologist ❑ Dermatologist ❑ Gastroenterologist

Have you had **nasal** or **sinus surgery**? ❑Yes ❑No When? Results

Have you been treated in **urgent care or ER** for asthma? ❑Yes ❑ No **Most Recent**

Have you had allergy **tests**? ❑Yes ❑ No When? Where?

Have you had allergy **shots**? ❑Yes ❑ No When? Where?

Your Environment

How long have you lived in Arizona? _____ **Where else** have you lived? _____

_____ Are you **better or worse** in Az? Better ☐ Worse ☐

Any pets? ☐Yes ☐ No Please List

Are **symptoms worse** when around your pet? Yes ☐ No ☐ Any **previous pets** in the home? ☐Yes ☐No

Any **smokers** in the home? ☐Yes ☐ No Does your home have a **swamp cooler**? ☐Yes ☐ No

Type of Home: ☐ Appartment/Condo. ☐House Has your home had **water or flood damage** ☐Yes ☐ No

What kind of work do you do? _____ Are symptoms worse at work? ☐Yes ☐ No

Have you **travelled out of the country** in the past year? ☐Yes ☐No Where? _____

Are there **other households** you visit frequently? ☐Yes ☐No Explain: _____

Family members with allergies/asthma? ☐ Mother_____ ☐ Father _____ ☐ Siblings _____

Please list **all current medications** including inhalers, over the counter medications, vitamins, and supplements

_____

_____

_____

_____

Any **medications that you do not tolerate**? ☐Yes ☐No If yes, list the medications and the reaction they caused

_____

_____

_____

Any **foods that you do not tolerate** ☐Yes ☐No If yes, list the foods and the reaction they cause

Medical History (check all that apply)

- ☐ Cataracts
- ☐ Glaucoma
- ☐ Hearing loss
- ☐ Frequent nose bleeds
- ☐ Nasal polyps
- ☐ Migraine headaches
- ☐ Pituitary disorder
- ☐ Thyroid disorder
- ☐ High blood pressure
- ☐ Coronary artery disease
- ☐ Irregular heart beat
- ☐ Enlarged heart
- ☐ Lung disease
- ☐ Sleep apnea
- ☐ Stroke
- ☐ Seizure disorder
- ☐ Acid reflux
- ☐ Irritable bowel
- ☐ Inflammatory bowel
- ☐ Diabetes
- ☐ Cancer
- ☐ Depression
- ☐ Anxiety

Other: (Please List)

Do you now or have you ever **smoked**? ☐Yes ☐No How much/ how long? _____

Additional information you would like to mention: