PLEASE FILL OUT THE FOLLOWING REGARDING THE ALLERGY PATIENT HISTORY AND RETURN ON THE DATE OF YOUR INITIAL VISIT:

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

1. I was referred to see the allergist by _____. My primary care physician is _____.
2. I am/was having the following problem:

_____

_____.

3. My emergency contact is _____. They can be phoned at _____.

4. If a child, Mom's name/number is _____ and Dad name/ number _____.

5. My daytime phone number best to be reached at is _____.

6. LIST **SURGERIES** OR **HOSPITALIZATONS**: _____

_____

7. LIST **CURRENT MEDICATIONS AND DOSAGES:** _____

_____

8. LIST ANY **MEDICATION ALLERGIES** AND WHAT **REACTION** YOU HAD: _____

_____

9. Does mother, father, sibling, or child have the following: **Circle all family members who have the condition**.

Hay fever or Allergy	Yes or No	Mother	Father	Sibling	Child
Sinus Problems	Yes or No	Mother	Father	Sibling	Child
Asthma	Yes or No	Mother	Father	Sibling	Child
Hives	Yes or No	Mother	Father	Sibling	Child
Eczema	Yes or No	Mother	Father	Sibling	Child
Food Allergy	Yes or No	Mother	Father	Sibling	Child

10. Does the patient **currently smoke**? Yes or No If so, How much?
Has the patient **ever smoked**? Yes or No If so, when did the patient quit?
Does the patient drink **alcohol**? Yes or No If so, how often?

11. Does the **patient work**? Yes or No What type of work does the patient do? _____

How long has the patient done this type of work? _____ Are symptoms worse at work? Yes or No

12. If the patient is a **child**, Do they attend **school** **daycare** **home sitter** If so, how many other children are in class? _____

13. I have noticed the following **triggers** make the patient's symptoms worse: Circle all that apply

GRASS WEED RAGWEED TREES DUST RAIN LEAVES/MULCH CAT DOG HORSE HAY

MOLD TOBACCO SMOKE WEATHER CHANGES RESPIRATORY INFECTIONS COLOGNES/STRONG ODORS

EMOTIONS UNKNOWN FOODS (PLEASE LIST) _____

PATIENT NAME: _____ DATE OF BIRTH: _____ DATE: _____

14. **Environmental History**: PLEASE ANSWER ALL QUESTONS BELOW, PAYING SPECIAL ATTENTION TO THE BOLD AREAS.

Do you live in a **house, apartment,** or **mobile home**? It is made of **brick**, **frame/siding**, **stone**, **block**.

Your home is **how old**? _____ and you have lived there **how long**? _____

Does your home have a **basement** or a **crawl space** or **cement foundation**? Is it **damp** or **dry**?

Is your house located in the **city**, **suburbs**, or **rural area**?

Do you use **gas**, **electric**, **heat pump**, or **wood** for heat? Do you use **central air** or **window unit** for air conditioning?

Do you use an **air cleaner, humidifier, dehumidifier, or none?** Is it used throughout the **whole home** or just in one **room**?

Does anyone **smoke** in the **home**? Yes or No Does anyone **smoke** in the **car**? Yes or No **How many smokers**? 1 2 3 4+

Do you have **stuffed toys in the bedroom**? Yes or No If so, approximately how many? _____

Do you have **indoor house plants**? Yes or No If so, **how many**? _____ How many are any in the **bedroom**? _____

Do you sleep with **feather** or **synthetic** pillows? **How old** are the pillows? _____ Are **allergen proof coverings** used? Yes or No

Do you sleep on a regular **mattress/box springs**, **foam mattress**, or **couch/futon**? How old is the **mattress**? _____

The bedroom floor is **carpet**, **tile**, **wood**, or **vinyl**?

Do you have indoor **cats** or **dogs**? Do they go in your bedroom? **Yes** or **No** Do they **sleep** in your **bed**? Yes or No

Do you have outdoor **cats** or **dogs** or other animals (please list)?

15. **Circle all that apply** to your current symptoms or your past chronic symptoms. Read **each category** next to the arrow.

Do you have:

- Skin condition like Eczema, Seborrhea, contact dermatitis, hives, swelling, rash
- Sinus pressure, fullness in sinus region, teeth ache Last xray of sinuses was? _____ Never
- Eyes that itch, burn, dryness, red eyes, water, swell, dark circles, glaucoma, contacts
- Ears that have fluid, pop, fullness, itching, ringing, ear aches, ear tubes, ear infections
- Nose that is stuffy, sniffling, itching, loss of smell or taste, nose bleeds, runny nose/what color ?
- Post nasal drip, tonsil or throat infections, bad breath, throat clearing, itching throat, hoarseness
- Cough, shortness of breath, wheezing in chest, waking in the night, chest tightness Last chest xray was?_____
  How often do you have chest symptoms? Daily, _____ x per week, _____ x per month, _____x per year
- High blood pressure, heart murmur, heart skips, coronary artery disease, heart palpitations
- Arthritis, fibromyalgia, lupus, other auto-immune disease
- Reflux/heartburn, suspected food reactions, hiatal hernia, ulcer
- Prostate problems, kidney disease, urinary retention
- Headaches, Migraines, seizures
- Thyroid problems, Diabetes