SOUTHWEST ALLERGY AND ASTHMA CENTER, P.A. – ALLERGY HISTORY FORM

PATIENT'S NAME	BIRTHDATE	APPOINTMENT DATE

BRIEFLY DESCRIBE REASON FOR ALLERGY VISIT.

HAVE YOU EVER HAD THE FOLLOWING CONDITIONS:

YES		NO	*(CHECK EACH ITEM)*	AGE OF ONSET	SEVERITY			MONTHS OF YEAR AFFECTED
PRESENT PROBLEM	PAST PROBLEM				MILD	MODERATE	SEVERE	
			Hay fever)itching of nose, sneezing, stuffy nose, running nose)					
			Asthma (wheezing)					
			Other Breathing Problems – Shortness of Breath					
			Hives or Swelling (urticaria-angioedema)					
			Sinus Trouble – Frequent Colds					
			Eczema or other rashes (Poison Oak, etc.)					
			Food Allergies					
			Immune Defect (frequent or recurrent infections)					**SEE BELOW IF YES**
			Drug Allergy (Penicillin, Sulfa, aspirin, other)					**SEE BELOW IF YES**
			Bee Sting or Insect Hypersensitivity (large swelling, hives, shock)					**SEE BELOW IF YES**

If yes to **DRUG ALLERGY**
Date of reaction(s) _____
_____
_____
I reacted to the following medication *(circle):*
Penicillin Sulfa Aspirin Other _____
(Specify) _____
I had the following reaction *(circle):*
Swelling Hives Other _____
Seizures Wheezing *(Specify)* _____
Shock Rash

If yes to **BEE STING**
Date of sing(s) _____
_____
_____
I reacted to the following medication *(circle):*
Honey Bee Hornet Other _____
Yellow Jacket Wasp *(Specify)* _____
I had the following reaction *(circle):*
Local Swelling Seizure Shock
Hives Faintness Other _____
Wheezing Rash *(Specify)* _____

SYMPTOMS: Have you ever had any of the following?

SYMPTOMS	DAYS IN LAST MONTH	SEVERITY			CIRCLE MONTHS THAT YOU HAVE SYMPTOMS
		MILD	MODERATE	SEVERE	
Sneezing					J F M A M J J A S O N D
Nasal Congestion or Runny Nose					J F M A M J J A S O N D
Itchy Nose or Eyes					J F M A M J J A S O N D
Coughing					J F M A M J J A S O N D
Wheezing					J F M A M J J A S O N D
Coughing or Wheezing with exercise					J F M A M J J A S O N D
Headaches					J F M A M J J A S O N D
Skin Problems					J F M A M J J A S O N D

GEOGRAPHIC HISTORY: Please list your last several residences (City & State only) with your most recent first and list effect on symptoms.		
Residence (City, State only)	Dates	Effect on Symptoms – i.e. better, worse, etc.
1. (Present)		
2.		
3.		

For each item below, check the proper box to show whether condition is made worse, condition is improved or unchanged. If item does not apply to you, check the box at right.

	CONDITION MADE WORSE	CONDITION IMPROVED	NO CHANGE	DOES NOT APPLY		CONDITION MADE WORSE	CONDITION IMPROVED	NO CHANGE	DOES NOT APPLY
Mowing lawn, walking on grass or playing in grass	☐	☐	☐	☐	Following rainfall	☐	☐	☐	☐
Raking leaves	☐	☐	☐	☐	Smoking or smoke exposure	☐	☐	☐	☐
Other outdoor activities	☐	☐	☐	☐	Use of hair sprays or tints, cosmetics, perfumes, deodorants, after-shave lotions, etc. *(Specify)* _____ _____ _____	☐	☐	☐	☐
High winds, or riding in auto with windows open	☐	☐	☐	☐	Taking of medication. Add product name if you remember it.	☐	☐	☐	☐
Sweeping, dusting, using vacuum cleaner	☐	☐	☐	☐	Antihistamines or cold tablets	☐	☐	☐	☐
Moldy or mildewed areas or articles	☐	☐	☐	☐	Nose drops or sprays _____ _____ _____	☐	☐	☐	☐
Contact with or nearness to any animals *(Specify)* _____ _____ _____ _____	☐	☐	☐	☐	Aspirin _____ _____ _____	☐	☐	☐	☐
Use of household cleaning agents, laundry soaps or detergents, etc. *(Specify)* _____ _____ _____ _____	☐	☐	☐	☐	Others *(Specify)* _____ _____ _____ _____	☐	☐	☐	☐
Use of paint, varnish, etc. *(Specify type)* _____ _____ _____ _____	☐	☐	☐	☐	Emotional upsets	☐	☐	☐	☐

Strong odors *(Specify)* _____ _____ _____ _____	☐	☐	☐	☐	Heavy physical exertion or exercise	☐	☐	☐	☐
Air conditioning, either at home or places you visit	☐	☐	☐	☐	Anything else you have noticed (Specify) _____ _____ _____ _____ _____	☐	☐	☐	☐
Trips away from home (Specify area and time of year) _____ _____ _____ _____	☐	☐	☐	☐		☐	☐	☐	☐

a. Have you ever noticed any symptoms (rash, hay fever, asthma, stomach ache, loose bowels, nausea) after any of the following foods *(Check appropriate boxes.)*

☐ MILK	☐ FISH	☐ SPICES	☐ GINGER	☐ ALCOHOL
☐ EGGS	☐ SHELL FISH	☐ COFFEE	☐ FRUITS	☐ WINE
☐ WHEAT	☐ PEANUTS	☐ MUSTARD	☐ VEGETABLES	☐ CHEESES
☐ BERRIES	☐ OTHER NUTS	☐ CHOCOLATE	☐ MEATS	☐ Other foods (List)
☐ MELON	☐ TOMATOES	☐ CELERY	☐ PASTRIES	_____

b. EXPLAIN

C. Have you ever had poison ivy or poison oak?
- ☐ Yes
- ☐ No

Have you ever had allergy skin tests?
- ☐ Yes If yes, Date _____ Doctor's Name _____
- ☐ No

Do you recall the results of these tests? *(If so list the positive results)*
_____
_____
_____

Did you ever receive allergy injections?
- ☐ Yes If yes, Date _____ Doctor's Name _____
- ☐ No

Please list ***all*** medications that you are now taking for your allergic conditions. *(If you don't know the name, give prescription number and druggist's phone or describe pill – color, shape)*
_____
_____
_____
_____
_____
_____

What other medications have you taken in the past for allergies?
_____

How frequently do you use a Nasal Spray?
_____

Who is your primary physician? _____ **Family Practice, Peds, Ind. Med., etc**

Other specialist seen on regular basis? _____ **Specialty?**
_____

MEDICAL CONDITIONS Please indicate if you currently have, or have had in the past, any of the following medical conditions:					
YES	**NO**	**(CHECK ALL THAT APPLY)**	**DESCRIPTION OF CONDITION & DATES**	**DATE RESOLVED**	**DOCTOR SEEN**
		Ear, Nose and Throat (Include nasal surgeries)			
		Eye Problems (Glaucoma, etc.)			
		Lungs (i.e. Asthma, Bronchitis, Pneumonia)			
		Tuberculosis			
		Heart/Blood Pressure			
		Intestinal or Stomach			
		Liver and/or Pancreas			
		Kidney Trouble			
		Reproductive			
		Neurological Condition (i.e. migraines, seizures, etc.)			
		Musculoskeletal Disorders			
		Skin Disorders			
		Diabetes			
		Cancer (please specify)			
		Psychological Condition			

List medications you take for medical conditions.			
DRUG (BRAND NAME)	**DOSE & HOW ADMINSTERED**	**DATE STARTED**	**MEDICATION TAKEN FOR:**

X-RAY HISTORY				
YES	**NO**	**X-RAY**	**DATES**	**FINDINGS**
		CHEST		
		SINUS		
		OTHER		

HOSPITALIZATIONS	**CAUSE**	**DATE**
Please list		

OPERATIONS	**CAUSE**	**DATE**
Please list		

FAMILY HISTORY

Is there a history of allergy in your family? *(i.e. parents, grandparents, brothers or sisters, children, aunts or uncles)*

☐ Yes If yes, list **Relationship.**

☐ No

Allergy	
Hay Fever	
Eczema	
Asthma	
Recurrent Pneumonia	
Hives	
Headaches	
Angioedema	
Swelling	

ENVIRONMENTAL HISTORY

What type of work do you do?

Are you exposed to anything at work that might aggravate your conditions?

Pre-School Children: Do they go to daycare?
How many days per week?

Have you missed any time from work or school because of you allergies? How much time?

Do you have any other unusual exposures from hobbies or etc.?

Where do you live? *(Area of city or in country)*

How old is your house? _____

Approximate Number of indoor house plants _____

Does your house have dampness, mold or mildew problems?
_____

Type of heating *(Forced hot air, hot water, steam space heater, baseboard, electric ceiling).*

Do you have air conditioning? _____

Do you have an air cleaner? _____

TYPE OF CARPET (Wool, Nylon, etc., Jute Backing) AND PAD (Rubber, Ozite, Hair) IN	BEDROOM	CARPET / PAD	LIVING ROOM	CARPET / PAD	DEN	CARPET / PAD	DINING ROOM	CARPET / PAD

Number of beds in your bedroom?

Does the bedroom or house tend to be dusty?

Is your pillow stuffed with
- ☐ Feather
- ☐ Foam
- ☐ Dacron
- ☐ Other *(Specify)* _____

Is your mattress
- ☐ Foam Rubber
- ☐ Innerspring
- ☐ Cotton
- ☐ Waterbed
- ☐ Other *(Specify)* _____

How old is your
Pillow _____ Mattress _____

Do you have any stuffed furniture?
- ☐ Yes
- ☐ No

Feather comforters?
- ☐ Yes
- ☐ No

Do you have any pets? **(Please list number)**
- ☐ Yes
- ☐ No

Please list number
- ☐ Dogs
- ☐ Cats
- ☐ Birds
- ☐ Other *(Specify)*

If yes, do they come inside?

Have you ever noted symptoms after exposure to them? Explain.

TOBACCO HISTORY

Do you currently smoke or use tobacco products?
- ☐ Yes
- ☐ No

Have you ever smoked or used tobacco products?
- ☐ Yes
- ☐ No

If yes, please indicate all that apply:
- ☐ Cigarettes* Year Quit: _____
- ☐ Cigars Year Quit: _____
- ☐ Pipe Year Quit: _____
- ☐ Snuff/Chewing Tobacco Year Quit: _____

* For cigarette use, please complete the following: _____ Number of packs per day _____ Number of years smoked