



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

<b>PATIENT'S NAME</b>	<b>BIRTHDATE</b>	<b>APPOINTMENT DATE</b>
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**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

<p>If yes to <b>DRUG ALLERGY</b> Date of reaction(s) _____ _____</p> <p>I reacted to the following medication (circle): Penicillin Sulfa Aspirin Other _____ (Specify) _____</p> <p>I had the following reaction (circle): Swelling Hives Other _____ Seizures Wheezing (Specify) _____ Shock Rash _____</p>	<p>If yes to <b>BEE STING</b> Date of sting(s) _____ _____</p> <p>I reacted to the following medication (circle): Honey Bee Hornet Other _____ Yellow Jacket Wasp (Specify) _____</p> <p>I had the following reaction (circle): Local Swelling Seizure Shock Hives Faintness Other _____ Wheezing Rash (Specify) _____</p>
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**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

<b>GEOGRAPHIC HISTORY:</b> 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Following rainfall	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Raking leaves	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Smoking or smoke exposure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other outdoor activities	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Use of hair sprays or tints, cosmetics, perfumes, deodorants, after-shave lotions, etc. (Specify) _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High winds, or riding in auto with windows open	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Taking of medication. Add product name if you remember it.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sweeping, dusting, using vacuum cleaner	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Antihistamines or cold tablets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Moldy or mildewed areas or articles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Nose drops or sprays _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contact with or nearness to any animals (Specify) _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Aspirin _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of household cleaning agents, laundry soaps or detergents, etc. (Specify) _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Others (Specify) _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Use of paint, varnish, etc. (Specify type) _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Emotional upsets	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Strong odors (Specify) _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heavy physical exertion or exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Air conditioning, either at home or places you visit	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Anything else you have noticed (Specify) _____ _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trips away from home (Specify area and time of year) _____ _____ _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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.)									
<input type="checkbox"/> MILK	<input type="checkbox"/> FISH	<input type="checkbox"/> SPICES	<input type="checkbox"/> GINGER	<input type="checkbox"/> ALCOHOL	<input type="checkbox"/> EGGS	<input type="checkbox"/> SHELL FISH	<input type="checkbox"/> COFFEE	<input type="checkbox"/> FRUITS	<input type="checkbox"/> WINE
<input type="checkbox"/> WHEAT	<input type="checkbox"/> PEANUTS	<input type="checkbox"/> MUSTARD	<input type="checkbox"/> VEGETABLES	<input type="checkbox"/> CHEESES	<input type="checkbox"/> BERRIES	<input type="checkbox"/> OTHER NUTS	<input type="checkbox"/> CHOCOLATE	<input type="checkbox"/> MEATS	<input type="checkbox"/> Other foods (List)
<input type="checkbox"/> MELON	<input type="checkbox"/> TOMATOES	<input type="checkbox"/> CELERY	<input type="checkbox"/> PASTRIES						
b. EXPLAIN					c. Have you ever had poison ivy or poison oak? <input type="checkbox"/> Yes <input type="checkbox"/> 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
<i>Please list</i>		

OPERATIONS	CAUSE	DATE
<i>Please list</i>		

FAMILY HISTORY	
Is there a history of allergy in your family? (i.e. parents, grandparents, brothers or sisters, children, aunts or uncles)	
<input type="checkbox"/> Yes      If yes, list <b>Relationship</b> . <input type="checkbox"/> No	
Allergy	
Hay Fever	
Eczema	
Asthma	
Recurrent Pneumonia	
Hives	
Headaches	
Angioedema	
Swelling	

<b>ENVIRONMENTAL HISTORY</b>								
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? <span style="float: right;">How much time?</span>								
Do you have any other unusual exposures from hobbies or etc.?								
Where do you live? ( <i>Area of city or in country</i> )				How old is your house? _____		Approximate Number of indoor house plants _____		
Does your house have dampness, mold or mildew problems? _____								
Type of heating ( <i>Forced hot air, hot water, steam space heater, baseboard, electric ceiling</i> ).				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	LIVING ROOM	CARPET	DEN	CARPET	DINING ROOM	CARPET
		PAD		PAD		PAD		PAD
Number of beds in your bedroom?				Does the bedroom or house tend to be dusty?				
Is your pillow stuffed with <input type="checkbox"/> Feather <input type="checkbox"/> Foam <input type="checkbox"/> Dacron <input type="checkbox"/> Other ( <i>Specify</i> ) _____				Is your mattress <input type="checkbox"/> Foam Rubber <input type="checkbox"/> Innerspring <input type="checkbox"/> Cotton <input type="checkbox"/> Waterbed <input type="checkbox"/> Other ( <i>Specify</i> ) _____				
How old is your Pillow _____ Mattress _____				Do you have any stuffed furniture? <input type="checkbox"/> Yes <input type="checkbox"/> No Feather comforters? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Do you have any pets? ( <b>Please list number</b> ) <input type="checkbox"/> Yes <input type="checkbox"/> No Please list number <input type="checkbox"/> Dogs <input type="checkbox"/> Cats <input type="checkbox"/> Birds <input type="checkbox"/> Other ( <i>Specify</i> )				If yes, do they come inside?				
Have you ever noted symptoms after exposure to them? Explain.								

<b>TOBACCO HISTORY</b>	
Do you currently smoke or use tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Have you ever smoked or used tobacco products? <input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please indicate all that apply:	
<input type="checkbox"/> Cigarettes*	Year Quit: _____
<input type="checkbox"/> Cigars	Year Quit: _____
<input type="checkbox"/> Pipe	Year Quit: _____
<input type="checkbox"/> Snuff/Chewing Tobacco	Year Quit: _____
* For cigarette use, please complete the following: _____ Number of packs per day _____ Number of years smoked	