ALLERGY HISTORY

Name: _____ Age: _____ Sex: _____
Address: _____
City: _____ State: _____ Zip: _____
Phone: Home (___) _____ Work (___) _____

1. In 5 words or less, describe your (or your child's) one most bothersome symptom such as "runny nose" or "shortness of breath": _____

2. Do you have any nasal symptoms? ❑yes ❑no if yes, how long ago or at what age did these symptoms first start? _____. Do you have at least some nasal symptoms year round? ❑yes ❑no
Please circle your worst seasons: Winter Spring Summer Fall
Have you ever used nasal sprays? ❑yes ❑no If yes, what type?
___ Prescription, (please list) _____
___ Over-the-counter (such as Afrin) _____
___ Salt water sprays (such as Ocean Spray) _____
Please check the nasal symptoms you have, or have had:
❑ stuffy nose ❑ runny nose ❑ postnasal drip ❑ itchy nose ❑ sneezing ❑ nose bleeding
What is the worst time of day for your nasal symptoms? _____

3. Do you have any eye symptoms? ❑ yes ❑ no. If yes, how long ago or at what age did these symptoms first start? _____ Do you have at least some eye symptoms year round?❑ yes ❑ no
Circle your worst seasons: Winter Spring Summer Fall
Have you ever used eye drops? ❑ yes ❑ no If yes, what type?
___ Prescription, (please list) _____
___ Over-the-counter (please list) _____
Please check the eye symptoms you have or have had: ❑ red eyes ❑ itchy eyes ❑ gritty feeling
What is the worst time of the day for your eye symptoms? _____

4. Have you ever had hives, whelps, itchy skin, other rash, or swelling of body parts?❑ yes ❑ no
If yes, please answer the rash/swelling questionnaire which is on page 8.

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PLEASE DO NOT WRITE BELOW THIS LINE

5. Have you ever had any chest symptoms? ❑ yes ❑ no. If yes, please check all that apply:
❑ shortness of breath ❑ chest tightness ❑ wheezing ❑ easy fatigue ❑ cough ❑ sputum
❑ others (please list) _____

6. If you have shortness of breath, wheezing or asthma, please answer the following:
Age at first onset: _____ Number of hospitalizations in your entire life including infancy and childhood for chest symptoms: _____ Number of these in the past 12 months: _____
How many times have you seen a doctor in his clinic for shortness of breath for which you would have gone to the Emergency Room if you had not been able to get into the clinic?
_____ in life _____ in past 12 months.
How many times in your entire life have you gone to the ER for shortness of breath?
_____ in life _____ in past 12 months.
In the past 12 months, how many days have you missed from school _____ work_____ because of shortness of breath? Do you have activity restriction because of shortness of breath?
❑ yes ❑ no If yes, please describe _____
Do you have sleep disturbance because of chest symptoms? ❑ yes ❑ no
If yes, how many nights per month: ____ Describe your symptoms that cause sleep disturbance:
_____
which of the following makes your shortness of breath worse?
❑ cold air ❑ cold symptoms ❑ exercise ❑ animals ❑ pollens
❑ menstrual period ❑ emotional upset ❑ molds ❑ stress
Are there months of the year when your shortness of breath seems to be worse?(check the worst ones)
❑Jan ❑Feb ❑Mar ❑Apr ❑May ❑June ❑July ❑Aug ❑Sept ❑Oct ❑Nov ❑Dec
Have you ever taken medication for chest symptoms? ❑ yes ❑ no. If yes, please list all medications you have ever used and the dose or number of puffs:
Inhalers: _____
_____
Pills: _____
_____
Liquids: _____
_____
Nebulizer: _____
Have you ever had steroid injections, liquids or steroid pills (Prednisone, Medrol, Prelone, Pediapred) for shortness of breath? ❑ yes ❑ no. If yes, how many different times _____.
Please list the name, dose and number of days taken _____
_____
Have you ever been placed on a machine to help you breathe or had a seizure from shortness of breath or stopped breathing? ❑ yes ❑ no. If yes, please describe _____
_____
If you have ever been hospitalized, how long do you usually stay in the hospital, number of days_____.
When was your last chest x-ray? _____ last TB skin test _____
Were you ever a smoker? ❑ yes ❑ no. If yes, how many years total did you smoke? _____
How many packs per day at the very most? _____ If you have stopped smoking, how long ago? _____ years _____ months.
Did you ever work in an occupation or have any hobbies in which you were exposed to dusts, mists, fumes, chemicals or radiation ❑ yes ❑ no. If yes, please describe _____
_____

Do you now or have you ever had animals of any type in your home? ❑ yes ❑ no. If yes, please list animals and your last exposure: _____

_____

Do you now have or have you ever had a peak flow meter? ❑ yes ❑ no. If yes, what is your usual morning reading? _____ PM or evening? _____

Do you ever have hot or sour material in the back of your throat when you bend down or lie down? ❑ yes ❑ no. Do you have heartburn? ❑ yes ❑ no. If yes, how often? _____

7. Do you cough up sputum? ❑ yes ❑ no. If yes, please answer the following:

How long have you had a problem with cough? _____

Do you have sputum? ❑ yes ❑ no. If yes, describe the color and list the quantity (such as ¾ teaspoon in 24 hours) _____

Have you ever coughed up blood? ❑ yes ❑ no. If yes, when was the last time _____

When was your last TB skin test? _____ last chest x-ray? _____ last sinus x-ray _____

Do you take medications for high blood pressure? ❑ yes ❑ no. If yes, please list name and dose

_____

Does any certain position make the cough worse? ❑ yes ❑ no. If yes, please describe:

_____

Is the cough worse any particular time of day? ❑ yes ❑ no. If yes, please describe:

_____

Do you have postnasal drip? ❑ yes ❑ no.

8. If you have trouble with walking medium distances because of shortness of breath, please answer the following:

How far can you comfortably walk now before having to stop and rest? _____

Six months ago _____ One year ago _____ Five years ago _____ Ten years ago _____

Check any of the following factors which you think bother you:

❑ air conditioning	❑ bright lights	❑ exercise	❑ other: _____
❑ fabrics	❑ chilling	❑ soaps	_____
❑ industrial fumes	❑ drafts	❑ pets	_____
❑ insecticides	❑ paint	❑ colds	_____
❑ worry	❑ varnish	❑ smoke	_____
❑ tension	❑ flowers	❑ newsprint	_____
❑ cosmetics	❑ trees	❑ strong odors	_____
❑ perfumes	❑ temperature change	❑ rain	_____
❑ dust	❑ grasses	❑ dampness	_____
❑ smog	❑ weeds	❑ menstrual period	_____

9. Do you have headaches not easily relieved by Tylenol? ❑ yes ❑ no. If yes, please answer the following: How long have you had headaches? _____ years _____ months. Which part of your head hurts? _____ How often do you get headaches _____? _____ headaches per month? How long do your headaches last? _____ to _____. What percent of these headaches are incapacitating? _____% Does light bother your eyes with some of the headaches? ❑ yes ❑ no. Do you have changes in your vision with these headaches? ❑ yes ❑ no. If yes, please describe: _____

Does noise bother you during these headaches? ❑ yes ❑ no. List all medications you have ever tried for these headaches (both prescription and over-the-counter) and if each helped you or not:

Circle any of these that you have ever had to evaluate your headaches:
Sinus x-ray CT of sinuses or brain MRI of brain

10. Do you have any of the following:

❑ itchy eyes	❑ colds that last more than 5 days	❑ nausea
❑ frequent ear infections	❑ inability to keep up with other children at play	❑ vomiting
❑ ear pain	❑ headaches – sinus	❑ diarrhea
❑ loss of sense of smell	❑ bloating	❑ weight loss
❑ poor sleep	❑ swelling of feet, hands or other body parts	
❑ frequent colds	❑ cystitis (bladder infections)	
❑ summer colds		

Other symptoms you attribute to allergic reaction: _____
_____

11. List all current medications including any over-the-counter to include vitamins, herbs, etc.
Name of med strength frequency of dosage
_____
_____
_____
_____
_____
_____
_____
list others on the back of this page

12. Are there any foods you cannot tolerate? List them and explain why:_____
_____
_____

13. Are there any medications you cannot tolerate? List them and explain reaction to each:
_____
_____

14. Have you ever had an allergic reaction to any type of flying, stinging insects or ants? List each and explain the reaction: _____
_____

15. Social History:
a. Occupation: _____
b. Hobbies: _____
c. Unusual chemical exposure: _____
_____
d. Smoking history _____ packs per day for _____ years. Stopped _____ years ago.
e. _____ cups of coffee per day _____ alcoholic drinks per week
f. Other: _____

16. Environmental History: Describe your home:

a. age of home _____ years b. Location: _____city _____ state

c. type of construction (brick, wood, etc) _____

d. type of heating (central, space, gas, electric) _____

e. type of cooling (central, window, fans, etc) _____

f. type of flooring in your bedroom _____

g. type of pillow (feather, synthetic, foam) _____

Does it have an anti-allergy cover ❑ yes ❑ no

h. type of mattress: innerspring _____ waterbed _____

Is the innerspring mattress covered with an anti-allergy cover ❑ yes ❑ no

i. Do you have pets? _____ If yes, please list each type. Do they ever come into the house?

❑ yes ❑ no

17. Review of systems: Please check each that you have had recently:

❑ fever ❑ chills ❑ night sweats ❑ unusual headaches

❑ ear pain ❑ loss of hearing ❑ change in vision other than need for glasses

❑ sore throat ❑ neck pain ❑ swollen glands in head or neck

❑ chest pain (describe) _____

❑ nausea ❑ vomiting ❑ vomiting blood ❑ diarrhea

❑ blood in stool ❑ black, tarry stool ❑ constipation ❑ painful urination

❑ blood in urine ❑ difficulty in starting or stopping urination ❑ intolerance of heat or cold

❑ excessive fatigue ❑ rash (fill out rash questionnaire)

❑ swelling of ankles or other joints (describe) _____

❑ unusual pain or weakness in bones, joints or muscles

❑ weight loss ____ lbs in _____ months ❑ weight gain ____ lbs in _____ months

❑ unsteady walking ❑ other (please describe) _____

_____

18. If the patient is a child less than 5, answer the following:

How many pregnancies preceded the birth of this child? _____

During the pregnancy were there any problems with the health of the mother or child?

_____

How was the child fed during the first year? ❑ Bottle ❑ Breast

If formula, which one? _____

When was solid food introduced? _____

Any problems with solid foods or formula? Please describe:

_____

19. Past medical history:

a. List <u>all</u> surgical procedures (tonsillectomy and ear tubes included)

_____

_____

b. List <u>all</u> hospitalization at any time during your life: _____

_____

c. Do you have or have you had:

❑ depression ❑ cystitis ❑ thyroid disease ❑ high blood pressure

❑ arthritis ❑ cancer ❑ irritable bowel syndrome ❑ heart disease

❑ hyperactivity ❑ peptic ulcer ❑ attention deficit disorder ❑ diabetes list others:

20. Health maintenance: Please list the last date each of the following was done, stating normal or abnormal: a._____ cholesterol _____ triglycerides
_____ glucose _____ thyroid test
_____ CBC(anemia)_____ chest x-ray
_____ TB skin test
stool for occult blood or other colon cancer screening tests _____
_____
b.females: last breast exam _____ last mammogram _____
last pelvic exam _____
c.males: last PSA _____
last digital rectal exam for prostate cancer _____
d.Please list date of last diphtheria tetanus shot _____
flu shot _____ pneumonia shot _____
e.If patient is less than 13, are all immunizations up-to-date? ❑ yes ❑ no
Are growth curves normal? ❑ yes ❑ no

21. Family History:
Is there any family history of colon cancer? ❑ yes ❑ no. If yes, give relationship to you and age of relative at diagnosis: _____
Is there any family history of breast or ovarian cancer? ❑ yes ❑ no. If yes, give relationship to you and age of relative at diagnosis: _____
Is there any history of prostate cancer? ❑ yes ❑ no. If yes, give relationship to you and age of relative at diagnosis. _____
Your mother: current age _____ medical problems _____
Your father: current age _____ medical problems _____
Number of brothers _____ medical problems _____
Number of sisters _____ medical problems _____
Number of children _____ medical problems _____
_____
_____
If mother or father is deceased, list age, cause of death and any other major health problems. If any of the other above family members are deceased, please list relationship, age at death, cause of death, any other medical problems:
_____
_____
_____
Please check if any of your family members have the following:

❑ asthma	❑ sinus	❑ migraines	❑ food allergy
❑ blocked nose	❑ hay fever	❑ nasal polyps	❑ drug allergy
❑ aspirin sensitivity	❑ eczema		

Out of the family members listed above, please list the ones with these problems.
_____
_____
_____

DO NOT WRITE ON THIS PAGE

VITAL SIGNS: T: _____ P _____ R _____ B/P _____
Head: _____ normocephalic _____ other
Ears: R: _____ frosty _____ red _____ bulging _____ NL
L: _____ frosty _____ red _____ bulging _____ NL

Eyes: ____ erythema _____ shiners _____ Dennie's _____ NL _____ white

Nose: ____ erythema _____ medium pink _____ light pink _____ pale
Edema: _____mild _____moderate _____severe
Mucous: _____clear _____white _____green _____yellow

Throat: ____ erythema _____ exudates
____ tonsillar enlargement _____ mild ____ medium ____ moderate ___ severe

Neck: ____ supple, no meningismus
____ no adenopathy ____ tender lymph nodes
____ enlarged lymph nodes: _____
____ thyroid normal ____ thyroid abnormal _____

Lungs: ____ clear ____ end expiratory wheezes
____ diffuse wheeze ____ rales ____ friction rub

Heart: ____ regular rate and rhythm ____ no murmur nor gallop
____ murmur heard _____
____ gallop heard _____
____ abnormal rhythm _____

Chest wall: ____ No tenderness to palpation ____ Tender to palpation

Abdomen: ____ Not examined
____ active bowel sounds with no masses, tenderness or organomegaly
____ Abnormal _____

Skin: ____ normal ____ atopic dermatitis _____
____ urticaria _____
____ angioedema _____

Extremities: _____
_____
_____

Notes: _____
_____
_____

HIVES, SWELLING, RASH OR ITCHING QUESTIONNAIRE

Complete this section only if you have ever had any of the above:

1. Date the problem first began (approximately) _____.

2. Date the CURRENT problem began _____.

3. How often do you have the problem (average) please circle one
every day 3-6 days per week 1-2 days per week less than weekly

4. Was any illness or event associated with the beginning of the present problem?
(example: cold with fever, drug reaction) please list: _____
_____

5. Have you ever had significant swelling of body parts such as eyelids, lips, etc.? Please list details: _____

6. What do you think might be the cause of the current problem? (put down what you really think, even if it might seem unreasonable) _____

7. What could have been the cause at other times? _____

8. How long do individual hives or whelps last after they appear realizing that each hive may be replaced by another lesion close by: (list in hours or days) _____

9. Did you require any injections for the problem? Please list the drug(s) if known
_____

10. Have you ever required an Emergency Room visit for the problem? ❑ yes ❑ no
If yes, please give details: _____
_____

11. If you have had this problem previously, when did it first begin and how long did it last?
_____

12. Do you suspect any food, beverage, candy, food coloring or other ingestant as a cause?
Please list details: _____
_____

13. Give an example of your usual diet for one full day _____
_____
_____
_____

14. Medications which cause hives, rash or swelling: (please specify) _____
_____
_____

15. Do you have contact with animals, insects, indoor plants, outdoor plants or chemicals?
❏ yes ❏ no If yes, please list details _____
_____
_____

16. Physical factors which create the problem or make it worse: (please circle all that apply)

heat	physical pressure	warm rain/showers	exercise-
cold	sun exposure	distilled liquor	vibration
emotions	beer/wine	stroking skin	running

other (specify) _____
_____
_____

17. When did the latest attack start and end? _____

18. Is there anything that makes the condition worse? _____

19. Estimate the number of days missed from work/school in the past year due to the problem:
_____

20. Have you ever had sinus infections or dental problems that could be associated with the current problem? ❏ yes ❏ no. If yes, give details: _____
_____
_____

21. What is the worst time of day for the problem? _____

22. List <u>all</u> medications taken in the past 3 months including all over-the-counter medications, herbs, vitamins, minerals, tonics, birth control pills, eye drops, patches, etc.: _____
_____
_____
_____
_____
_____
_____

23. Do you place anything on your skin? ❑ yes ❑ no. If yes, please give details: _____
_____
_____
_____

24. Are there any foods or food additives that you cannot eat? ❑ yes ❑ no. If yes, please explain: _____
_____
_____

25. Are there any medications that you cannot tolerate? ❑ yes ❑ no. If yes, please explain if not listed previously: _____

26. Have you ever had allergy tests before? _____ By whom: _____
When: _____

27. How many tests? _____ what method _____
what tests were strong positives _____
_____

28. Have you ever traveled outside the continental USA? ❑ yes ❑ no. If yes, list country and year: _____

29. Do you work with any unusual chemicals or materials at work or at home? ❑ yes ❑ no.
If yes, please list them: _____
_____
_____

30. Please list any other information that you feel I should know: _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
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_____