



Name _____ DOB _____

ALLERGY HISTORY
(please circle all applicable items or write in)

Informant: Patient
Parent (M, F)
Relative

CHIEF COMPLAINT:

- 1.
- 2.
- 3.

DOCTOR'S NOTES

Other health concerns: _____

Onset of problem: infancy childhood teens age _____ or year _____

Areas lived: _____ Time in Northwest: _____

AREAS AFFECTED: Eyes Ears Nose Throat Lungs Digestive Skin

SYMPTOMS: Itching Tearing Sneezing Runny nose Congestion Snoring Postnasal drip

Bad breath Headache Cough Bronchitis Tightness Wheezing Shortness of breath

Throat clearing Diarrhea Heartburn Rash Hives Swelling Pain Infection

Fatigue Ear popping/plugging Other _____

WHAT FACTORS CAUSE OR WORSEN SYMPTOMS?:

Spring Summer Fall Winter In house Outside Daycare School 2nd home

Stress Sun Work Dust Dogs Cats Feathers-down Other animals _____

Trees Grass Weeds Mold-mildew Cold air Heat Exercise Smoke/Pollution

Fumes/Chemical odors Soaps/Detergents Aspirin Weather changes Insect stings

Viral colds Other _____

Foods: _____

Latex reactions: _____

PREVIOUS ALLERGY EVALUATION AND MEDICATIONS PRESCRIBED:

When? _____ Where? _____ MD? _____ Skin tests? _____

Treatments Tried: _____ Pills: _____

Nasal sprays: _____ Inhalers: _____

Allergy shots - Years _____ Steroids (prednisone) _____

SOCIAL HISTORY:

Marital status: Single Married Divorced Widowed # of children at home _____

Current occupation: _____ Hobbies _____

Smoke/Chew Tobacco: Current - How much per day? _____ How long? _____

Past - How much/day? _____ When did you quit? _____ Attempts to quit? _____

Alcohol use - Drinks/day: _____ Drug use: _____

FAMILY HISTORY:

Good Health Nasal Allergy Asthma Skin Allergy Food Allergy Other Diseases

Grandparents _____

Aunts/Uncles _____

Parents _____

Siblings _____

Children _____

PAST MEDICAL HISTORY:

Current and "as needed" Medications from all physicians (including over-the-counter products and vitamins): _____

Drug Reactions: _____ Insect Sting Reactions: _____

Hospitalizations: _____ ER Visits: _____

Surgery: _____

Chronic Medical Problems, past and present:

Arthritis	Glaucoma	Hiatal hernia	Pneumonia
Cancer	Heart Disease	Kidney Stones	Thyroid Disease
Diabetes	High Blood Pressure	Migraine Headaches	Positive Tuberculin Test/TB
Epilepsy/Seizures	Hepatitis	Osteoporosis	Ulcers

Other _____

For Children < 5 y/o

Birth History: Birth Weight _____ Complications _____

Breast Feeding _____ Formula (type) _____

REVIEW OF SYSTEMS:

Do you CURRENTLY have or have you RECENTLY had any of the following? Circle none if negative.

none	Constitutional	fever	fatigue	weight gain or loss _____ #	appetite change
		night sweats	cold intolerance	heat intolerance	sleep problems
none	Eyes	vision changes	glaucoma	conjunctivitis	blurry vision
		cataracts	dry eyes	itchy eyes	tearing
none	ENT	hearing changes	ringing in ears	loss of balance	ear infections
		loss of sense of smell or taste	deviated septum	sinusitis	runny/stuffy nose
none	Heart	blood pressure	murmur	abnormal EKG	chest pain
		fast/irreg heartbeat	palpitations	swelling of ankles	
none	Pulmonary	cough	wheeze	shortness of breath	bronchitis
					pneumonia
none	Digestive	nausea	vomiting	diarrhea	ulcer
				heartburn	constipation
		liver or gall bladder	hepatitis	change in bowel habits	
		abdominal pain	excessive gas	gallstones	blood in stool
none	Urinary	bedwetting	painful urination	urinary tract infections	prostate
none	Musculoskeletal	arthritis	back pain	muscle aches	cramping
		sports injury	joint swelling	osteoporosis	
none	Skin	psoriasis	tumors	dry skin	eczema
				rash	hives
					hair loss
none	Endocrine	diabetes	thyroid		
none	Blood/Lymph	anemia	bleeding	bruising	cancer
					swollen glands
none	Reproductive	menstrual problems	menopause	yeast infections	pregnancies _____
		Planning Pregnancy? _____	When? _____		
none	Neuro	seizures/epilepsy	migraines	head injury	fainting spells
		difficulty with memory	inability to concentrate	daytime sleep	
none	Psych/Social	mental illness	depression	drug/alcohol	stress
		marital problems	other _____		

REVIEW OF SYSTEMS

ENVIRONMENTAL HISTORY:

Current Home:

how old? _____ house apartment trailer condo own/rent how long here? _____

Location: city suburb country Outdoor factors (trees/fields/swamps) _____

Heat/Ventilation: baseboard wall units radiator wood stove space heater radiant

Forced air (furnace heat pump) air conditioner (window/central)

Filter? none fiberglass HEPA electrostatic air cleaner

How often changed or cleaned? _____ ducts cleaned? _____

Mold/Mildew: basement laundry kitchen bath humidifier/dehumidifier

Vacuum type: canister upright central BAG: permanent disposable HEPA water

Rooms with carpeting: bedroom living room TV room how old? _____

Patient's Bedroom: Mattress: regular waterbed foam futon

Pillow: foam feather/down synthetic

Bedding: cotton synthetic feather/down how many stuffed animals? _____

Pets: Outdoor _____ Indoor _____

Smokers in home: none patient mother father spouse/partner child packs/day _____

Other exposures: daycare school second home

ENVIRONMENTAL

Reviewed with patient by MD _____ Date _____