ALLERGY HISTORY

Name: _____ **Date**_____

WHICH SYMPTOMS HAVE YOU EXPERIENCED?

[ ] Hay Fever
[ ] Runny Nose
[ ] Stuffy Nose
[ ] Sinus Problems
[ ] Itching Eyes
[ ] Post Nasal Drip
[ ] Sneezing
[ ] Arthritis
[ ] Asthma

[ ] Cough
[ ] Cough at Night
[ ] Wheezing
[ ] Shortness of Breath
[ ] Tight Chest
[ ] Exercise Problems

[ ] Headache
[ ] Diarrhea
[ ] Constipation
[ ] Stomach Problems
[ ] Hives
[ ] Severe Acne
[ ] Eczema
[ ] Rashes

[ ] Colitis
[ ] Mental Dullness
[ ] Nausea
[ ] Fatigue
[ ] Sleep Problems
[ ] Mood Changes

Known Allergies: _____

How long have you had these symptoms: [ ] 0-1 yrs [ ] 1-5 yrs [ ] 5-10 yrs [ ] 10+ yrs

What time of year do you have these symptoms? Jan Feb Mar Apr May Jun Jul Aug Sept Oct Nov Dec All Year

What do you think you are allergic to? _____

Are your allergies worse when you are outside [ ] Yes [ ] No

Have you been evaluated for allergies before? [ ] Yes [ ] No **When?** _____

Where? _____ **Do you receive allergy shots?** [ ] Yes [ ] No

Is there a family history of allergies or asthma? [ ] Mother [ ] Father [ ] Siblings [ ] Other

Do you have frequent sinus infections? [ ] Yes [ ] No **How many per year?** _____

Are you exposed to smoke? [ ] Yes [ ] No

Do you smoke? [ ] Yes [ ] No **How much?** _____ **How long?** _____

Who is your family Physician? _____

Current Medications? _____

Are you allergic to any medications? [ ] Yes [ ] No **What?** _____

HOME ENVIRONMENT:

How long have you lived in the Tri-Cities? _____ **How long in your present home?** _____

Type of home? _____ **Age of home?** _____ **Carpeting?** _____

Is there Water/Mildew damage? _____

Heating/Cooling [ ] Central [ ] Floor Furnace [ ] Wood Stove [ ] Window A/c [ ] Filters [ ] Other

Do you have pets? [ ] Cat [ ] Dog [ ] Other

WORK ENVIRONMENT:

Occupation: _____ **Do symptoms get worse at work?** _____

Toxic Exposure: [ ] Solvents [ ] Chemicals [ ] Fumes [ ] Dust [ ] Mildew