

ALLERGY HISTORY

Date : _____

Name : _____

Date of Birth : _____

Address: _____

Home Phone : _____

Work Phone : _____

Occupation : _____

For How Long : _____

Main Complaint : _____

Prior Allergy Treatment or Testing : Yes / No (If Yes, Where & When) _____

Other Medical Problems : _____

List Major Surgeries and Dates : _____

List ALL medications now being taken (including over-the-counter and vitamins/herbal supplements)

CIRCLE ALL SYMPTOMS YOU HAVE EXPERIENCED :

NOSE: Itching – sneezing – nasal congestion (stuffy) – runny nose – post nasal discharge – redness – frequent “colds” – polyps – sinus trouble – sinus infections, ___ # per year

EYES : Itching – puffiness – blurred vision – excessive tearing – dark circles under eyes – discharge – visual disturbances

EARS : Itching – itching deep in ears – tinnitus (ringing) – dizziness – popping – fullness – pressure – hearing loss – drainage (discharge) – red- frequent infections, ___ # per year

MOUTH & THROAT Frequent sore throats – itching of palate or back of throat – difficulty swallowing lump sensation – laryngitis – need to clear mucous in the morning – mouth ulcers – swelling of lips – swelling of tongue – scratchy or burning sensation

CHEST: Cough – wheezing – shortness of breath – pain – tightness – asthma – frequent chest colds or infections – chronic obstructive pulmonary disease (COPD) frequent attacks of bronchitis, ___ # per year

**GASTRO
INTESTINAL:** Belching – bloating – heartburn – retasting of foods – cramping – bad breath excessive gas – diarrhea – constipation – poor appetite – irritable bowel syndrome

- GENITO URINARY :** Difficulty voiding – frequency – urgency – burning – prostatitis – vaginitis – itching – frequent urinary infections – frequent yeast infections
- SKIN :** Hives – rashes – eczema – swelling – itching – reactions to cosmetics – Blisters or peeling of hands – athlete’s foot – jock itch
- NEUROLOGICAL:** Headache (sinus – migraine – tension) – decreased attention span – Learning disability – seizures – inability to concentrate – poor memory
- MISCELLANEOUS :** Joint pain – muscle pain – arthritis – restless legs – chronic fatigue – insomnia

ANSWER ALL QUESTIONS BELOW WHICH PERTAIN TO YOU :

Seasonal Incidence :

Do you have trouble or is your condition worse :

- | | | | |
|----|---------------------|-----|----|
| 1. | In the Spring | Yes | No |
| 2. | In the Summer | Yes | No |
| 3. | In the Fall | Yes | No |
| 4. | In the Winter | Yes | No |

Describe your allergy “attack” symptoms :

- | | | | |
|----|--|-----|----|
| 5. | Do your attacks last | | |
| | A few minutes | Yes | No |
| | Several hours | Yes | No |
| | Several days | Yes | No |
| | A whole season | Yes | No |
| | The whole year | Yes | No |
| 6. | Do the attacks occur regularly at a particular time of day or night .. | Yes | No |
| 7. | Have you found anything which will relieve attacks | Yes | No |
| 8. | Will the attacks cause you to lose sleep | Yes | No |
| 9. | Will the attacks interrupt your daily routine | Yes | No |

Childhood History :

- | | | | |
|-----|---|-----|----|
| 10. | Did you have eczema | Yes | No |
| 11. | Did you have colic | Yes | No |
| 12. | Were you often sick | Yes | No |
| 13. | Did you have bronchitis or asthma | Yes | No |
| 14. | Did you have croup | Yes | No |
| 15. | Did you have frequent attacks of “stomachache,” diarrhea, or vomiting | Yes | No |
| 16. | Did you have frequent colds | Yes | No |
| 17. | Did you have frequent ear infections | Yes | No |
| 18. | Did you have sinus trouble | Yes | No |
| 19. | Did you have frequent sore throats | Yes | No |

Family History :

Have any members of your family (this includes mother, father, grandparents, aunts, uncles, Brothers, sisters, and children) had any of the following diseases:

- | | | | |
|-----|---|-----|----|
| 20. | Asthma | Yes | No |
| 21. | Hay Fever | Yes | No |
| 22. | Nasal allergy (frequent attacks of sneezing, runny/stuffy nose, post nasal drip)
..... | Yes | No |
| 23. | Hives | Yes | No |
| 24. | Eczema | Yes | No |
| 25. | Chronic skin disease | Yes | No |
| 26. | Frequent headaches | Yes | No |
| 27. | Migraine | Yes | No |

Non-pollen Inhalant History

House Dust

Do you notice that your trouble begins or is aggravated :

- | | | | |
|-----|--|-----|----|
| 28. | When the house is being cleaned or swept | Yes | No |
| 29. | When rugs are being cleaned or vacuumed | Yes | No |
| 30. | When the bed is being made or the mattress being turned | Yes | No |
| 31. | During spring house cleaning | Yes | No |
| 32. | When you sit on old, overstuffed furniture | Yes | No |
| 33. | In such dusty places as: theaters, churches, grocery stores, department stores, libraries,
Your bedroom | Yes | No |

Atmospheric Mold :

Do you notice that your trouble begins or is aggravated :

- | | | | |
|-----|--|-----|----|
| 34. | During prolonged periods of damp or humid weather | Yes | No |
| 35. | When you are around where grass is being mowed or weeds are being cut | Yes | No |
| 36. | When you are near hay or straw (as at the circus, in a barn around a haystack, on a hayride)
..... | Yes | No |
| 37. | When you go into an old damp house, a damp basement, shed or cellar | Yes | No |
| 38. | When you enter a closet in which are stored old shoes, unused luggage, gloves, or
Other leather goods | Yes | No |
| 39. | If you eat cheese, mushrooms, cantaloupe, or drink beer | Yes | No |
| 40. | When the first cold snap of autumn | Yes | No |

Animals :

Do you notice that your trouble begins or is aggravated :

- | | | | |
|-----|---|-----|----|
| 41. | When lying on a feather pillow | Yes | No |
| 42. | When fluffing pillows | Yes | No |
| 43. | If you use a down comforter | Yes | No |
| 44. | If you are near chickens, ducks, geese, pigeons, parrots, turkeys, canaries, or other birds
..... | Yes | No |
| 45. | If you are around anyone who works around poultry or other fowl | Yes | No |
| 46. | Do you have pets in the house or yard | Yes | No |
| 47. | When you are around any of the following animals : dogs, cats, horses, goats,
Rabbits, cows, hogs or sheep | Yes | No |
| 48. | When you handle or come into contact with any of the following : furs, rugs, certain
Articles of clothing, dress goods, blankets, gloves, hats, toy animals, or brushes
..... | Yes | No |

Smoke :

Do you notice that your trouble begins or is aggravated :

- | | | | |
|-----|--|-----|----|
| 49. | When you smoke | Yes | No |
| 50. | When you are in nightclubs or other smoky places | Yes | No |

Orris Root :

Do you notice trouble begins or is aggravated :

- | | | | |
|-----|---|-----|----|
| 51. | When using face, talcum, body, bath, or tooth powder | Yes | No |
| 52. | In beauty parlors or barber shops | Yes | No |
| 53. | When you are around people who use a lot of powder or perfume | Yes | No |

Pyrethrum – Orris Root – Lethane – Paradichlorobenzene :

Do you notice that your trouble begins or is aggravated :

- | | | | |
|-----|---|-----|----|
| 54. | When you are exposed to household insect powders or sprays | Yes | No |
| 55. | When you are exposed to powders, sprays, or crystals used for
moth-proofing purposes | Yes | No |
| 56. | When you are exposed to dusting powders or sprays used in
the gardens or on crops | Yes | No |

Food History :

- 57. Do you suspect any food in causing or aggravating your condition... Yes No
- 58. Are there any foods which you dislike Yes No
- 59. Are there any foods in which you over-indulge or eat frequently because
You like them so much Yes No
- 60. Is there any seasonal food (i.e., strawberries) in which you over-indulge Yes No
- 61. Are there any foods you find difficult to digest Yes No
- 62. Do any foods you eat cause nausea, vomiting, diarrhea, heartburn, belching,
Gas on the stomach, cramps, hives, skin rashes, headaches (Circle those that apply)
- 63. Are you on any type of diet at present Yes No

Physical History :

Does your trouble at times seem to begin or become aggravated :

- 64. By change in the weather Yes No
- 65. By exercise Yes No
- 66. By fatigue Yes No
- 67. By loss of sleep Yes No
- 68. By excitement Yes No
- 69. By emotional upheaval Yes No
- 70. By a hot or cold bath Yes No
- 71. By becoming overheated Yes No
- 72. By prolonged periods of physical or mental work or prolonged stress
(As when there is someone sick in the family) Yes No
- 73. As a result of "nervousness" Yes No
- 74. Air conditioning Yes No

Focal Infection History :

- 75. Are you conscious of a foul odor in your nose Yes No
- 76. Do you have a dripping from the back of your nose into your throat
which has a "sickening sweet" taste or is yellow or green like pus . Yes No

Environmental Survey (Home Survey):

- 77. Is your house old Yes No
- 78. Is your house new Yes No
- 79. Is your house damp Yes No
- 80. Is your house dry Yes No
- 81. Do things mildew easily around the house Yes No
- 82. Near your house, is there :
 - A factory Yes No
 - A railroad Yes No
 - A lake Yes No
 - A poultry yard Yes No
 - A swampy area Yes No
 - Lots of weeds Yes No
 - Anything you suspect as a possible cause of your symptoms Yes No
- 83. Is your home heated by :
 - Open gas heaters Yes No
 - Floor gas furnaces Yes No
 - Radiators Yes No
 - Open fireplaces Yes No
 - Central heating system with ducts Yes No
- 84. Is your home cooled by:
 - An attic fan Yes No
 - Window air conditioning Yes No
 - Central air conditioning Yes No
 - Window fans Yes No
- 85. Do you have plants in the house or in window planter boxes Yes No

- | | | | |
|-----|---|-----|----|
| 86. | Do you use insect sprays or moth repellents in the house | Yes | No |
| 87. | Do you keep any books or magazines that gather dust in the house | Yes | No |
| 88. | Do you have overstuffed furniture | Yes | No |
| 89. | Do you use feather pillows | Yes | No |
| 90. | Do you use down comforters on the bed | Yes | No |
| 91. | Do you have rugs on the floor | Yes | No |
| 92. | Do you use padding under your rugs | Yes | No |
| 93. | Do you have draperies on the windows | Yes | No |
| 94. | Do you have throw pillows around the house | Yes | No |
| 95. | Are there any smells or fumes continuously or frequently present
about the house | Yes | No |
| 96. | Is there any place in the house where you have symptoms regularly | Yes | No |
| 97. | Are the walls of your house covered with wallpaper | Yes | No |
| 98. | Is there any type of business enterprise carried out in your house . | Yes | No |
| 99. | Are you engaged in a hobby in your house | Yes | No |

Work or School Survey :

- | | | | |
|------|--|-----|----|
| 100. | Do you have symptoms at work or school | Yes | No |
| 101. | Is the place where you work or attend school : | | |
| | Damp | Yes | No |
| | Cooled with window or attic fans | Yes | No |
| | Air conditioned | Yes | No |
| | Centrally heated | Yes | No |
| | Dusty | Yes | No |
| | Smoky | Yes | No |
| 102. | As far as you know, do you inhale anything at work or school which
might cause or aggravate your symptoms | Yes | No |
| 103. | Are there fumes, gases, smokes or odors where you work or
or attend school | Yes | No |

Activities :

- | | | | |
|------|--|-----|----|
| 104. | Do you take part in any outdoor sports or hobbies | Yes | No |
| 105. | Are you better when you are away from home on a trip, such as
vacation time | Yes | No |

Previous Treatment History :

- | | | | |
|------|--|-----|----|
| 106. | Have you ever had any operations for your condition | Yes | No |
| 107. | Have any of the treatments or drugs prescribed given prolonged
relief | Yes | No |