# ALLERGY HISTORY

Date: _____ Referred by: _____

Name: _____ DOB: _____

Occupation: _____ For how long: _____

Main Complaint: _____

_____

Prior Allergy Treatment or Testing: ____ Yes ____ NO (If yes, when and where) _____

_____

Other Medical Problems _____

_____

List Major Surgeries and Dates: _____

_____

List ALL Medications now being taken: _____

_____

CIRCLE ALL SYPTOMS 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 outer corner – itching inner corner- puffiness – blurred vision – excessive tearing- dark circles – 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 – re-tasting of food – cramping – bad breathe - excessive gas – diarrhea – constipation – poor appetite – irritable bowel syndrome |
| GENITO-URINARY: | Difficulty voiding – frequency – urgency – burning – prostatitis – vaginitis – itching – 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 |
| NEURO-LOGICAL: | Headaches (sinus – migraine – tension) – decreased attention span – learning disability – seizures – inability to concentrate – poor memory |
| MISC.: | 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 you 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 season ..... YES NO
6. Do 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 "stomach ache", 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 nose, blockage of 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 INHALATION 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 ..... 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: theatres, churches, grocery stores, department stores, libraries, your bedroom ..... YES NO

### Atmospheric Mold

Do you notice that our trouble begins or is aggravated:

34. During prolonged periods or 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 hay ride) ..... YES NO
37. When you go in to 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 pillow ..... 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. Do you smoke ..... YES NO
50. When you are in night clubs or other smoky places ..... YES NO

**Orris Root**

Do you notice that your trouble begins or is aggravated:

51. When using face, talcum, body, bath or tooth power ..... 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 powder or sprays ..... YES NO
55. When you are exposed to powders, sprays or crystals used for mothproofing purposes ..... YES NO
56. When you are exposed to dusting powders or sprays used in the garden 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 (for example, 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, bleeding, gas on the stomach, cramps, hives, skin rashes, headaches (circle those that apply) ..... YES NO
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 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 it 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
    - If so _____
83. Is your house heated by:
    - Open gas heaters ..... YES NO
    - Floor gas heaters ..... YES NO
    - Radiators ..... YES NO
    - Open fireplace ..... YES NO
    - Central heating system with ducts ..... YES NO
84. Is your house 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
    If so where _____
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 aggravate your symptoms ..... YES NO
103. Are there fumes, gases, smokes or odors where you work 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

## GENERAL MEDICAL HISTORY

1. Do you often have pain in the face ..... YES NO
2. Do you often experience flushing of the face with a sensation of warmth ..... YES NO
3. Do you often suffer pains in the eyes ..... YES NO
4. Do you experience a sense of burning or dryness in the nose or sense of stuffiness, rather than actual blockage ..... YES NO
5. Do you often have pain inside of your nose ..... YES NO
6. Are you bothered with a bad odor inside of your nose ..... YES NO
7. Do you frequently blow large, dried crusts or scabs from your nose ..... YES NO
8. Have you ever had severe nose bleeds ..... YES NO
9. Have you ever fallen or been hit hard on the nose ..... YES NO
10. Has your nose ever been broken ..... YES NO
11. Have you ever been told you have a crooked bone in your nose ..... YES NO
12. Have you ever had an operation on your nose or sinuses ..... YES NO
13. Are you bothered by soreness or burning in your mouth ..... YES NO
14. Do you have bad breathe at times ..... YES NO
15. Are you often bothered with a sensation of dryness in your mouth ..... YES NO
16. Is your tongue often sore ..... YES NO
17. Do you often find yourself grinding your teeth or do people tell you that You grind your teeth while sleeping ..... YES NO
18. Do you often have pain around your eyes when you chew ..... YES NO
19. Do the glands in your neck swell when you get sore throats ..... YES NO
20. Have your tonsils been removed ..... YES NO
21. Did you ever have to take a breathing test ..... YES NO
22. Do you have chronic chest trouble (except asthma) ..... YES NO