_____INTIALS

ALLERGY SYMPTOMS

Please circle all related symptoms

General: Fever, Weakness, Fatigue, Weight Loss or Gain, Dizziness, Night sweats.

Nose: Congestion, Runny Nose, Clear Mucus, Colored Mucus, Headache, Sneezing, Itchy Nose, Mouth or Ears.

Throat: Sore throat, Cough, Itchy throat, Lump in throat, Swelling, Hoarseness.

Eyes: Itching, Redness Pain, Tearing, Discharge, Swelling of lid, Lid rash, Sticky eyelids.

Ears: Earache Rt or Lt, Ear pressure Rt or Lt, Ear Infection Rt or Lt , Popping Rt or Lt, Hearing loss Rt or Lt, Ringing Rt or Lt.

Chest: Cough, Shortness of Breath, Wheezing, Noisy breathing, Phlegm, Chest tightness, Chest Pain, Asthma, Bronchitis, COPD, Pneumonia.

Abdominal: Indigestion, Heartburn, Reflux, Difficulty swallowing, Pain, Vomiting, Diarrhea, Blood in Stool.

Skin: Itching, Rash, Hives, Swelling, Sores Bites, Eczema, Hair loss, Pus, Acne, Burning, Lumps.

Allergy: Please specify the reaction that happens.

Allergy to foods _____

_____

Allergy to Medications_____

_____

Other_____

Last name, First initial (print) _____

Additional Information:

Name of referring doctor: _____

Name of primary care:_____

Specialist doctors: _____

Pharmacy: _____

Sexual orientation/ pronouns/ other important information (optional)

_____

_____

_____INTIALS

FAMILY HISTORY

Please list which member of your family that has history of any of the below listed illnesses and on which side Maternal-(mother's side) Paternal (father's side)

Allergies_____
Asthma_____
Eczema_____
Hives/Swelling_____
Food Allergies_____
Drug Allergies_____
Diabetes _____
Cancer_____
Arthritis_____

Immune Disorder_____
Other Illnesses_____
_____

Your Current Medication List_____

_____
_____
_____
_____
_____
_____

_____INTIALS

OTHER HEALTH PROBLEMS

_____

_____

_____

PAST MEDICAL, SURGICAL, HOSPITALIZATION HISTORY

_____

_____

_____

SOCIAL HISTORY

Marital Status - Married Single Divorced Separated Child (circle)

Occupation - _____

Student – Yes No (circle) If yes Grade _____/Level _____

Smoking History- Never Current Former (circle)
Cigarette packs_____ number of years _____

Residence- House Apartment / Flooring - Carpeting Hardwood (circle) Central Air Yes No

Pets /Number Cats _____ Dogs_____ Other (specify)_____

Alcohol Use _____ Drug Use _____

Caffeine ____

Passive Smoker_____

Children Yes No (circle) How many_____

Allergy History

Please describe your current symptoms:

_____

_____

_____

What time of year do you have symptoms? Please grade 0 (none) to 4+ (severe)

	Winter	Spring	Summer	Fall	Year round
Nasal/sinus					
Eye					
Chest/asthma					
Eczema					
Hives					
Other					

Please circle any triggers to your symptoms.

Pollen. Grass cutting. Leaf raking. Tree pollen. Mold. Dust. Cats. Dogs. Other pets. Feathers.

Smoke. Weather changes. Seasonal Changes. Rainy weather. Humid weather. Hot weather.

Cold air. Exhaust. Exercise. Other: _____

What treatments have you tried in the past? What worked and what didn't help?

_____

_____

_____

Please describe any allergy testing performed in the past and include results if available.

_____

_____

_____