Patient Name: _____ Patient DOB: ____/____/_____ Date: ____/____/_____

PATIENT HISTORY

Medical Conditions		Additional Information
High blood pressure	☐ YES ☐ NO	
Eosinophilic Esophagitis	☐ YES ☐ NO	
Heart Disease	☐ YES ☐ NO	
COPD/Chronic Bronchitis	☐ YES ☐ NO	
Uncontrolled Asthma	☐ YES ☐ NO	
Stroke	☐ YES ☐ NO	
Immune Disorders (HIV, rheumatoid arthritis, cancer, etc.)	☐ YES ☐ NO	

Are you pregnant? ☐ YES ☐ NO ☐ N/A

Do you have the skin condition called ***dermographism***? ☐ YES ☐ NO

Have you ever had a severe anaphylactic (allergic) reaction that required emergency medical attention? If yes, explain: ☐ YES ☐ NO _____

List **all current medications,** including prescribed and OTC medications:

NAME	TAKEN FOR	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Allergy History

When did allergies begin? (Year) _____

Do symptoms include itching and sneezing? ☐ YES ☐ NO

When do symptoms occur? (check all that apply)

☐ All months			
☐ January	☐ April	☐ July	☐ October
☐ February	☐ May	☐ August	☐ November
☐ March	☐ June	☐ September	☐ December

When are symptoms worse?

☐ Morning	☐ Afternoon	☐ Evening	☐ Night
☐ At home	☐ At work	☐ At school	☐ Other location: _____
Symptoms are:	☐ Constant	☐ Occasional	☐ Rare

Symptoms interfere with activities:

☐ Not at all ☐ Mildly ☐ Moderately ☐ All the time

Which of the following cause or make symptoms worse? (Check all that apply)

FOOD

☐ Meat	☐ Wine	☐ Mushrooms	☐ Milk / milk products	☐ Fruit juices
☐ Beer	☐ Cheese	☐ Poultry	☐ Fish	☐ Wheat products
☐ Nuts	☐ Chicken	☐ Vinegar	☐ Eggs/egg products	☐ Vegetables

Patient Name: _____ Patient DOB: ____/____/_____ Date: ____/____/_____

☐ Liquors ☐ Other: (list all) _____

ENVIRONMENT

☐ Wind	☐ Smoke	☐ Barns/Hay	☐ High pollution	☐ Damp areas
☐ Soap	☐ Powder	☐ Mowing lawns	☐ Insecticides	☐ Dust
☐ Paint fumes	☐ Perfumes	☐ Cosmetics	☐ Newspapers	☐ Wool
☐ House plants	☐ Weather change	☐ Wet weather	☐ Dry weather	☐ Hot day
☐ Cold day	☐ Air-conditioning	☐ Travel	☐ Furniture	☐ Feather pillows
☐ Hay	☐ Cut grass	☐ Cut flowers	☐ Rugs/rug pads	☐ Christmas trees
☐ Stuffed toys	☐ Other: (list all) _____			

Indoors, explain: _____

Outdoors, explain: _____

PETS

☐ Birds ☐ Cat: Indoor / Outdoor ☐ Dog: Indoor / Outdoor ☐ Cattle ☐ Horse

☐ Other: (list) _____

Place **X** under self or **age** of family members with any of the following medical conditions:

Condition	Self	Father	Mother	Brothers	Sisters	Children
Migraine						
Hay Fever						
Hives						
Eczema						
Asthma						
Food Allergies						

Allergy Care History

List any OTC or Prescribed medications taken for allergy symptoms and when:

NAME	DOSE/FREQUENCY	DATE STARTED	LAST TIME TAKEN

Other

Have you (patient) had an allergy shot in the last two weeks? ☐ YES ☐ NO If yes, explain _____

Have you (patient) had any vaccine within the last 48 hours? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to latex? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to rubbing alcohol? ☐ YES ☐ NO If yes, explain _____

Do you (patient) have an allergy to any medications? ☐ YES ☐ NO If yes, explain _____

For Provider Use Only:

NOTES:

_____ _____ ____/____/_____

Patient/Guardian Printed Name Patient/Guardian Signature Date

_____ _____ ____/____/_____

Provider Printed Name Provider Signature Date