ALLERGY HISTORY

ENT Physician: Dr.______________________ Primary Physician: Dr.______________________

Name: ____ Date: ______________________

Address: ____

Best phone number to reach you: ________________________ Alternate: ____________________

Occupation: ____ How long? _________________

Social Security # ____________________ Primary Insurance: _____________________________

Main Complaint: ____

Prior Allergy Treatment or Testing: Yes / No (If yes, where and when) ___________________

____

Other Medical Problems: ____

List Major Surgeries and dates: ____

List ALL medications now being taken (prescription and over-the-counter): ________________

____

Do you take a Beta-blocker? Yes / No If yes, how long? ________________________________

Drug Allergies: ____

CIRCLE ALL SYMPTOMS YOU HAVE EXPERIENCED:

NOSE:	itching sneezing nasal congestion (stuffy) runny nose redness polyps post nasal drainage frequent *"colds"* sinus trouble sinus infections ____ # per year
EYES:	itching outer corner itching inner corner puffiness blurred vision excessive tearing dark circles under eyes discharge visual disturbances
EARS:	redness itching itching deep in ears tinnitus (ringing) dizziness popping fullness pressure hearing loss drainage or discharge frequent ear infections ____# per year
MOUTH & THROAT:	frequent sore throat itching of roof of mouth or back of throat mouth ulcers difficulty swallowing lump sensation laryngitis scratchy/ burning sensation need to clear mucus in the morning swelling of tongue swelling of lips

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CHEST:	asthma cough wheezing shortness of breath painful breaths tightness COPD (chronic obstructive pulmonary disease) bronchitis ______ # per year frequent chest colds or infections ______ # per year
GASTRO-INTESTINAL:	belching bloating heartburn re-tasting of foods cramping bad breath excessive gas diarrhea constipation poor appetite irritable bowel syndrome
NEURO-LOGICAL:	headaches (sinus, migraine, tension) decreased attention span learning disability seizures inability to concentrate poor memory
SKIN:	hives rashes eczema swelling itching blisters or peeling of hands
MISC:	joint pain muscles pain arthritis restless legs chronic fatigue insomnia

CIRCLE OR GIVE WRITTEN ANSWERS:

Childhood History:
As a child did you have: **eczema** **frequent bronchitis** **asthma** **sinus trouble** **frequent colds** **frequent ear infections** **frequent sore throat**

Family History:
Is there a history of allergies or asthma in your family? Yes / No
If yes, who in your family, and indicate allergies or asthma: ______________________________

Seasonal incidence:
Do you have trouble –or- is your condition worse in the: **spring** **summer** **fall** **winter**

Describe your allergy *"attacks"*:
Do your *"attacks"* last: **minutes** **hours** **days** **the whole season**
What time of day do your *"attacks"* usually occur? ______________________________________

Animals:
Pets in the house: Cat #____ Dog #_____ Bird #_____ Other: ________________
Do you use down comforters or feather pillows? Yes / No
Do you have air-tight mattress & pillow casings? Yes / No

Smoke:
Do you smoke? Yes / No

Food History:
List any food allergies you may have: n/a ____

Home Survey:
Age of home: # of __ years Central air/heat: Yes / No Carpet in bedroom: Yes /No