Is It Allergy? Patient History Form

Understanding the causes of your allergy-like Upper Respiratory Symptoms

Date ____________

Patient's Name	Last	First	Initial	Sex	Age

Street	City	State	ZIP

Home Telephone No. ( ) Area Code ____ Number ____

Parent's Name (If under 18) Last ____ First ____ Initial ____

To be filled out by patient.

Your answers to the following questions will help determine the cause of your allergy-like symptoms. It is important to check (✓) each question as accurately as possible.

Have trouble with your nose?	Yes	No	Don't Know
Clear/colorless discharge	❑	❑	❑
Thick/colored discharge	❑	❑	❑
Nasal itching/rubbing	❑	❑	❑
Constant stuffiness	❑	❑	❑
Periodic stuffiness	❑	❑	❑
Sniffles	❑	❑	❑
Sneezing	❑	❑	❑
Mouth breathing or snoring	❑	❑	❑
Have trouble with your eyes?			
Redness	❑	❑	❑
Itching	❑	❑	❑
Tearing	❑	❑	❑
Puffiness	❑	❑	❑
Have trouble with your throat?			
Frequently sore/drainage	❑	❑	❑
Itching throat/mouth	❑	❑	❑
Have trouble with your ears?			
Popping	❑	❑	❑
Itching	❑	❑	❑
Hearing loss	❑	❑	❑
Fluid in ears	❑	❑	❑
Infection/pain	❑	❑	❑
Have trouble with your skin?			
Eczema	❑	❑	❑
Hives	❑	❑	❑
Have trouble with your chest?			
Wheezing with colds	❑	❑	❑
Wheezing when exposed to dust, pollen, animal, etc.	❑	❑	❑
Wheeze/cough after exercise	❑	❑	❑
Have the following type of cough?			
Deep or productive	❑	❑	❑
Loose	❑	❑	❑
Constant	❑	❑	❑
Dry/tight	❑	❑	❑
Daytime	❑	❑	❑
Nighttime	❑	❑	❑
Are your symptoms:			
Mild	❑	❑	❑
Moderate	❑	❑	❑
Severe	❑	❑	❑
Present most of the time	❑	❑	❑
Present part of the time	❑	❑	❑
Present rarely	❑	❑	❑
Interfering with your life	❑	❑	❑
Preventing many normal activities	❑	❑	❑

Which of the following do you think cause your symptoms or make them worse?	Yes	No	Don't Know
Location:			
Indoors	❑	❑	❑
Outdoors	❑	❑	❑
At home	❑	❑	❑
At work	❑	❑	❑
Time of day:			
Morning	❑	❑	❑
Afternoon	❑	❑	❑
At night	❑	❑	❑
Weather/change in weather:			
Wet weather	❑	❑	❑
Dry weather	❑	❑	❑
Windy day	❑	❑	❑
Hot day	❑	❑	❑
Cold day	❑	❑	❑
Environment:			
Air conditioning	❑	❑	❑
Damp areas	❑	❑	❑
In barns	❑	❑	❑
Around hay	❑	❑	❑
Mowing lawn	❑	❑	❑
Dust	❑	❑	❑
High air pollution	❑	❑	❑
Animals	❑	❑	❑
Cooking odors	❑	❑	❑
Smoke	❑	❑	❑
Soap powder	❑	❑	❑
Insecticides	❑	❑	❑
Paint fumes	❑	❑	❑
Perfumes	❑	❑	❑
Cosmetics	❑	❑	❑
Newspapers	❑	❑	❑
Wool	❑	❑	❑
Food:			
Milk or milk products	❑	❑	❑
Eggs	❑	❑	❑
Wheat products	❑	❑	❑
Soy	❑	❑	❑
Nuts, beans, or seeds	❑	❑	❑
Chocolate	❑	❑	❑
Fish	❑	❑	❑
Meat	❑	❑	❑
Fruit	❑	❑	❑
Vegetables	❑	❑	❑
Cheese	❑	❑	❑
Mushrooms	❑	❑	❑
Beer	❑	❑	❑
Wine	❑	❑	❑
Other alcoholic beverages	❑	❑	❑

Possible causes of symptoms (continued)	Yes	No	Don't Know
Drugs:			
Aspirin	❑	❑	❑
Penicillin	❑	❑	❑
Other ____________			

Chemicals (list): ____________

During what months do you usually have symptoms?	Yes	No	Don't Know
All months	❑	❑	❑
January	❑	❑	❑
February	❑	❑	❑
March	❑	❑	❑
April	❑	❑	❑
May	❑	❑	❑
June	❑	❑	❑
July	❑	❑	❑
August	❑	❑	❑
September	❑	❑	❑
October	❑	❑	❑
November	❑	❑	❑
December	❑	❑	❑

Describe the symptoms that bother you most: ____________

When did your condition begin? ____________

	Yes	No	Don't Know
Do you use medication regularly for nasal symptoms?	❑	❑	❑

What medications? ____________

	Yes	No	Don't Know
Do they help?	❑	❑	❑
Do any of your blood relatives have allergies?	❑	❑	❑
Have you ever had a test for allergies?	❑	❑	❑
Blood test?	❑	❑	❑
Skin test?	❑	❑	❑
When were you tested? ____________			
Did the test indicate allergies?	❑	❑	❑

To what allergens? ____________

	Yes	No	Don't Know
Have you received allergy shots?	❑	❑	❑

More questions on reverse side...

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Exposure to smoke	Yes	No	Don't Know
Smokers in your home?	❑	❑	❑
Do you smoke?	❑	❑	❑

Years smoked:_______________

Year stopped smoking:___________

Do you use medications daily or frequently?	Yes	No	Don't Know
Antihistamine	❑	❑	❑
Aspirin/pain reliever	❑	❑	❑
Decongestant	❑	❑	❑
Cortisone	❑	❑	❑
Laxatives	❑	❑	❑
Sedatives	❑	❑	❑
Birth control pills	❑	❑	❑
Vitamins	❑	❑	❑
Ointments	❑	❑	❑
Nose drops/sprays	❑	❑	❑
Hormones	❑	❑	❑
Blood pressure medications	❑	❑	❑
Chlolesterol-lowering agents	❑	❑	❑

Others (list):

____

____

Do you spend a good deal of time in activities?	Yes	No	Don't Know
Hobbies (list):	❑	❑	❑
Sports (list):	❑	❑	❑
Other (list):	❑	❑	❑

Do you have animals in your home? (list)	❑	❑	❑
Have you ever had animals in your home? (list):	❑	❑	❑

Where do you live?	Yes	No	Don't Know
In the city	❑	❑	❑
In the suburbs	❑	❑	❑
Rural	❑	❑	❑
House	❑	❑	❑
Apartment	❑	❑	❑
Is your dwelling:			
New	❑	❑	❑
3-10 years old	❑	❑	❑
11-25 years old	❑	❑	❑
> 25 years old	❑	❑	❑

Have you had any of the following medical conditions?	Yes	No	Don't Know
High blood pressure	❑	❑	❑
Migraine headaches	❑	❑	❑
Skin condition	❑	❑	❑
Heart disease	❑	❑	❑
Frequent headaches	❑	❑	❑
Sinus problems	❑	❑	❑
Stomach problems	❑	❑	❑
Asthma	❑	❑	❑
Nasal polyps	❑	❑	❑
Emphysema	❑	❑	❑
Broken nose	❑	❑	❑
Overactive thyroid	❑	❑	❑
Bronchitis	❑	❑	❑
Nasal surgery	❑	❑	❑
Underactive thyroid	❑	❑	❑
Hay fever	❑	❑	❑
Deviated septum	❑	❑	❑
Hormonal problems	❑	❑	❑
Hives	❑	❑	❑
Nosebleeds	❑	❑	❑
Food allergy	❑	❑	❑
Drug allergy (describe):	❑	❑	❑
Other conditions (describe):	❑	❑	❑
Are you taking medication for any of the previous conditions? (describe):	❑	❑	❑

Describe your occupation:

____

____

	Yes	No	Don't Know
Do you think your work or school environment has anything to do with your symptoms?	❑	❑	❑
Do you think that any materials used in your occupation have something to do with your condition? (describe materials):	❑	❑	❑
At work/at school, are your symptoms:			
Better	❑	❑	❑
Worse	❑	❑	❑
The same	❑	❑	❑

Bedding	Yes	No	Don't Know
Do you sleep with a pillow?	❑	❑	❑
Is it dacron/synthetic?	❑	❑	❑
Is it foam rubber?	❑	❑	❑
Is it feather?	❑	❑	❑
Other (describe):	❑	❑	❑
Is your mattress:			
Cotton	❑	❑	❑
Feather	❑	❑	❑
Foam rubber	❑	❑	❑
Horsehair	❑	❑	❑
Other (describe):	❑	❑	❑

Household heating/cooling	Yes	No	Don't Know
Do you use a humidifier?	❑	❑	❑
Do you have an air conditioner:			
At work	❑	❑	❑
At home	❑	❑	❑
In bedroom	❑	❑	❑
Central	❑	❑	❑
Is your heating system:			
Oil	❑	❑	❑
Gas	❑	❑	❑
Coal	❑	❑	❑
Electric	❑	❑	❑
Other (describe):	❑	❑	❑
Is heat delivered by:			
Blower	❑	❑	❑
Radiators	❑	❑	❑
Electric panels	❑	❑	❑
Other (describe):	❑	❑	❑

Is there anything else about your problem that you think might be important or unusual?

____

____

Notes:______________________________

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