ALLERGY CLINIC Idaho

my allergy history

Name Full Name _____

Today's Date _____

Symptoms: Please mark which symptoms you have or have had in the past year.

NASAL / SINUS ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Nasal congestion	☐	☐	Headaches	☐	☐	Snoring	☐	☐
Relieved by decongestants	☐	☐	Bad breath	☐	☐	Nose bleeds	☐	☐
Not relieved by decongestants	☐	☐	Unpleasant taste	☐	☐	Rubbing of nose	☐	☐
Itching	☐	☐	Facial discomfort	☐	☐	Loss of sense of smell	☐	☐
Sneezing	☐	☐	Clear discharge	☐	☐	Recurrent sinus infections	☐	☐
Runny Nose	☐	☐	Thick discharge	☐	☐	Fatigue	☐	☐
Post nasal drainage	☐	☐	Mouth breathing	☐	☐	Loss of sleep	☐	☐

EYES ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Itching	☐	☐	Burning	☐	☐	Dark circles	☐	☐
Watery	☐	☐	Puffy/Swollen	☐	☐	Other: _____		

THROAT ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO	
Itching	☐	☐	Recurrent sore throat	☐	☐	Other: _____
Loss of voice	☐	☐	Chronic sore throat	☐	☐	_____
						_____

EARS ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO	
Popping	☐	☐	Dizzy	☐	☐	Other: _____
Hearing loss	☐	☐	Infections	☐	☐	_____
						_____

COUGH ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Continuous	☐	☐	Barking	☐	☐	With Sputum	☐	☐
Day time	☐	☐	Interferes with sleep	☐	☐	Deep	☐	☐
Night time	☐	☐	Dry with no sputum	☐	☐	Exercise makes worse	☐	☐

FOOD ALLERGIES ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Foods causing:								
Allergic reaction	☐	☐	Hoarsenes	☐	☐	Wheezing	☐	☐
Itching of mouth	☐	☐	Change of voice	☐	☐	Shortness of breath	☐	☐
Swollen tongue	☐	☐	Cough	☐	☐	Loss of consciousness	☐	☐
Swollen lips	☐	☐	Hives	☐	☐	Light headed	☐	☐
Itching of throat	☐	☐	Nausea or vomiting	☐	☐	Palpitations	☐	☐
Tightness of throat	☐	☐	Diarrhea or cramps	☐	☐			

Patients Initials _____

FREQUENT INFECTIONS ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Chronic infections	☐	☐	Recurrent Infections	☐	☐	Skin Rashes	☐	☐
Incomplete clearing of infection	☐	☐	Poor response to treatment	☐	☐	Growth failure	☐	☐
						Diarrhea	☐	☐

ONSET

Please check the specific symptoms and the season when it occurs/is worse. Leave blank if the specific symptom is not a problem.

	Spring	Summer	Fall	Winter	Arising	Morning	Afternoon	Evening	Night
Wheeze	☐	☐	☐	☐	☐	☐	☐	☐	☐
Cough	☐	☐	☐	☐	☐	☐	☐	☐	☐
Shortness of breath/ Chest tightness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nasal stuffiness	☐	☐	☐	☐	☐	☐	☐	☐	☐
Nasal itching	☐	☐	☐	☐	☐	☐	☐	☐	☐
Sneezing	☐	☐	☐	☐	☐	☐	☐	☐	☐
Eye symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐
Throat symptoms	☐	☐	☐	☐	☐	☐	☐	☐	☐
Fatigue	☐	☐	☐	☐	☐	☐	☐	☐	☐

AGGRAVATING FACTORS: Please mark what makes your symptoms worse.

Animals ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO	
Cats	☐	☐	Dogs	☐	☐	Other: _____

WEATHER ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Cold	☐	☐	Humidity	☐	☐	Temperature Changes	☐	☐
Heat	☐	☐	Air Conditioning	☐	☐	Weather Changes	☐	☐

INFECTIONS ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO	
Colds	☐	☐	Sinus Infections	☐	☐	Other: _____

IRRITANTS ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Dust	☐	☐	Non-chemical odors	☐	☐	Pollution	☐	☐
Perfumes / scents	☐	☐	Chemical fumes	☐	☐	Smoke	☐	☐

ACTIVITIES ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO	
Gardening	☐	☐	Raking Leaves	☐	☐	Other: _____
Mowing grass	☐	☐	Exercising	☐	☐	_____
						_____

LOCATION ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO	
Work	☐	☐	Home	☐	☐	Other: _____
School	☐	☐	Farm	☐	☐	_____
						_____

Patients Initials_____

AGGRAVATING FACTORS (continued): Please mark what makes your symptoms worse.

MEDICATIONS ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Pain medications	☐	☐	Blood Pressure (ACE inh.)	☐	☐	Aspirin	☐	☐
Beta blockers	☐	☐	Eye drops	☐	☐	Topical decongestants	☐	☐

OTHER ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO	
Foods	☐	☐	Pregnancy	☐	☐	Other: _____
Menstrual cycle	☐	☐	Psychological factors	☐	☐	_____
						_____

TRAVEL ☐ Yes ☐ No (if no, go to the next section)

	YES	NO		YES	NO		YES	NO
Salt air	☐	☐	Mountains	☐	☐	Urban areas	☐	☐
Humidity	☐	☐	Desert	☐	☐	Rural areas	☐	☐

CURRENT ENVIRONMENT ☐ Yes ☐ No

Type of home _____

Age of home _____

Time at current residence _____

YOUR ENVIRONMENT:

WORK ENVIRONMENT

	YES	NO		YES	NO		YES	NO
Office	☐	☐	Farm	☐	☐	Daycare	☐	☐
Factory	☐	☐	School	☐	☐	Other:_____		
Outdoors	☐	☐	Health Care Facility	☐	☐	_____		

HEATING/COOLING

	YES	NO		YES	NO		YES	NO
Electric	☐	☐	Kerosene	☐	☐	Air Conditioner	☐	☐
Gas	☐	☐	Wood Stove	☐	☐	Swamp Cooler	☐	☐
Oil	☐	☐	Forced Aire	☐	☐	HEPA Filter	☐	☐
Propane	☐	☐	Hot water	☐	☐			

AGRICULTURAL EXPOSURE

	YES	NO		YES	NO		YES	NO
Hay	☐	☐	Alfalfa	☐	☐	Corn	☐	☐
Wheat	☐	☐	Potatoes	☐	☐	Other_____		
Sugar beets	☐	☐	Livestock	☐	☐	_____		

COOKING

	YES	NO		YES	NO		YES	NO
Gas	☐	☐	Electric	☐	☐	Propane	☐	☐

FLOOR COVERINGS

	YES	NO		YES	NO		YES	NO
Wood	☐	☐	Linoleum	☐	☐	Carpeting, no pads	☐	☐
Tile	☐	☐	Carpeting & Pads	☐	☐	Rugs	☐	☐

Patients Initials_____

YOUR ENVIRONMENT (continued):

WALL COVERINGS

	YES	NO		YES	NO		YES	NO
Wall paper	☐	☐	Paneling	☐	☐	Sheetrock	☐	☐
Fabric wall "paper"	☐	☐	Tapestries	☐	☐	Plaster	☐	☐

WINDOW COVERINGS

	YES	NO		YES	NO		YES	NO
Washable curtains/drapes	☐	☐	Shades	☐	☐	Vertical Blinds	☐	☐
Unwashable curtains/drapes	☐	☐	Horizontal blinds	☐	☐	Other_____		

FURNITURE

	YES	NO		YES	NO		YES	NO
Wood	☐	☐	Fabric upholstery	☐	☐	House plants	☐	☐
Metal	☐	☐	Leather upholstery	☐	☐			
Plastic	☐	☐	Vinyl upholstery	☐	☐			

YOUR BEDROOM

	YES	NO		YES	NO		YES	NO
Bare floors	☐	☐	Curtains	☐	☐	Down comforter	☐	☐
Bare floors with rugs	☐	☐	Blinds	☐	☐	Chenille bedspread	☐	☐
Carpeting	☐	☐	Stuffed animals	☐	☐	Other_____		

YOUR MATTRESS

	YES	NO		YES	NO	
Innerspring	☐	☐	Foam rubber	☐	☐	Other_____
Waterbed	☐	☐	Futon	☐	☐	_____
						_____

YOUR PILLOWS

	YES	NO		YES	NO	
Feather or down	☐	☐	Kapok	☐	☐	Other_____
Foam rubber	☐	☐	Dacron or polyester	☐	☐	_____
						_____

PETS

	YES	NO		YES	NO		YES	NO
Outdoor cat now	☐	☐	Indoor cat in past	☐	☐	Indoor dog now	☐	☐
Outdoor cat in past	☐	☐	Outdoor dog now	☐	☐	Indoor dog in past	☐	☐
Indoor cat now	☐	☐	Outdoor dog in past	☐	☐	Birds	☐	☐

Other_____

OTHER FACTORS

	YES	NO		YES	NO		YES	NO
2nd hand smoke	☐	☐	Dampness	☐	☐	Symptoms with hobbies	☐	☐
Mold or mildew	☐	☐	Damp basement	☐	☐	Latex/rubber exposure	☐	☐
Water damage	☐	☐	Window condensation	☐	☐			

Patients Initials_____

PREVIOUS TREATMENT:

HAVE YOU BEEN ALLERGY TESTED? ☐ Yes ☐ No (if no, go to the next section)

TYPE:	YES	NO		YES	NO		YES	NO
Do not recall	☐	☐	Prick Test	☐	☐	IDT	☐	☐
Scratch Test	☐	☐	SET	☐	☐	RAST	☐	☐
Other	☐	☐						

ALLERGIC TO:	YES	NO		YES	NO		YES	NO
Dust	☐	☐	Weeds	☐	☐	Cats	☐	☐
Trees	☐	☐	Grass	☐	☐	Dogs	☐	☐
Molds	☐	☐	Other_____					

PREVIOUS PHYICIANS TREATMENT ☐ Yes ☐ No (if no, go to the next section)

	YES	NO	Helpful	Not Helpful
Medications	☐	☐	☐	☐
immunotherapy shots (weekly)	☐	☐	☐	☐
Reaction to shots?	☐	☐	☐	☐
Steroid Injections (Depomedrol/Kenalog)	☐	☐	☐	☐
SET	☐	☐	☐	☐

Explain_____

NASAL, ALLERGY, & ASTHMA MEDICATIONS

Please mark all medications that you are currently or have previously taken.

ANTIBIOTICS

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Amoxicillin	☐	☐	Ceftin	☐	☐	Omnicef	☐	☐
Augmentin	☐	☐	Doxycycline	☐	☐	Suprax	☐	☐
Avelox	☐	☐	Dynabac	☐	☐	Tequin	☐	☐
Bactim/Septra	☐	☐	E-mycin	☐	☐	Vantin	☐	☐
Biaxin	☐	☐	Levaquin	☐	☐	Zithromax (Z-Pack)	☐	☐
Ceclor	☐	☐	Lorabid	☐	☐	Other_____	☐	☐

ANTIHISTAMINE/DECONGESTANT COMBINATION

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Allegra D	☐	☐	Comhist LA	☐	☐	Semprex D	☐	☐
Claritin D	☐	☐	Rynatan	☐	☐	Trinalin	☐	☐

ANTIHISTAMINES

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Allegra	☐	☐	Clarinex	☐	☐	Periactin	☐	☐
Benadryl	☐	☐	Hydroxyzine	☐	☐	Zyrtec	☐	☐
Claritin	☐	☐	Over the counter	☐	☐	Other_____	☐	☐

Patients Initials_____

ASTHMA

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Accolate	☐	☐	Brethine	☐	☐	Serevent	☐	☐
Advair	☐	☐	Flovent	☐	☐	Singulair	☐	☐
Aerobid	☐	☐	Intal-Foradil	☐	☐	Theophyline	☐	☐
Albuterol	☐	☐	Maxair	☐	☐	Vanceril	☐	☐
Atrovent	☐	☐	Prednisone	☐	☐	Ventolin/Proventil	☐	☐
Azmacort	☐	☐	Pulmicort	☐	☐	Other_____	☐	☐
Beclovent	☐	☐	QVAR	☐	☐	_____		

DECONGESTANTS

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Entex	☐	☐	Sudafed	☐	☐	Other:_____	☐	☐

EYEDROPS

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Acular	☐	☐	Crolom	☐	☐	Patanol	☐	☐
Claritin D	☐	☐	Livostin	☐	☐	Other:_____	☐	☐

NASAL SPRAY

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Astelin	☐	☐	Flonase	☐	☐	OTC nasal spray	☐	☐
Atrovent nasal spray	☐	☐	Nasacort	☐	☐	Rhinocort	☐	☐
Beconase	☐	☐	Nasarel	☐	☐	Vancenase	☐	☐
Cromolyn nasal spray	☐	☐	Nasonex	☐	☐	Other:_____	☐	☐

HEARTBURN MEDICATION

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Aciphex	☐	☐	Prevacid	☐	☐	Zantac	☐	☐
Antacids (OTC)	☐	☐	Prilosec	☐	☐	Other:_____	☐	☐
Axid	☐	☐	Protonix	☐	☐	_____	☐	☐
Nexium	☐	☐	Tagamet	☐	☐	_____	☐	☐

COMPLICATIONS OF MEDICATIONS

	PRESENT	PAST		PRESENT	PAST		PRESENT	PAST
Aspirin allergy	☐	☐	Singing problems	☐	☐	Speech problems	☐	☐
Fatigue	☐	☐	Sleep apnea	☐	☐	Other:_____	☐	☐
Hearing Loss	☐	☐	Nasal septal perforation	☐	☐	_____	☐	☐
Nasal polyps	☐	☐				_____	☐	☐

Patients Initials_____

FAMILY HISTORY OF ALLERGY: To the best of your knowledge, mark which family members have the following history.

	Nasal Allergies	Asthma	Sinus Problems	Chronic Post Nasal Drainage	Hives	Food Allergies	Drug Allergies
Father	☐	☐	☐	☐	☐	☐	☐
Mother	☐	☐	☐	☐	☐	☐	☐
Brother(s)	☐	☐	☐	☐	☐	☐	☐
Sister(s)	☐	☐	☐	☐	☐	☐	☐
Children	☐	☐	☐	☐	☐	☐	☐
Grandparents	☐	☐	☐	☐	☐	☐	☐
Aunt(s)	☐	☐	☐	☐	☐	☐	☐
Uncle(s)	☐	☐	☐	☐	☐	☐	☐
Cousin(s)	☐	☐	☐	☐	☐	☐	☐

Physician Comments_____

_____

_____

_____

_____

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_____

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Patient Signature_____

Physician Signature_____

Patients Initials_____