Patient History
Allergy Diagnosis

Name ____________________________________  Occupation ________________________________
Address __________________________________ Company _________________________________
City ____________  State ____  Zip ____________  Day Phone ________________________________
Age _________________  Sex ________________  Evening Phone ____________________________

Which of the following symptoms have you experienced?  Please circle all that apply.

Hay fever  Asthma  Headache  Eczema
Runny nose  Cough  Diarrhea  Colitis
Stuffy nose  Cough (night only)  Constipation  Sleep problems
Sinus problems  Wheezing  Stomach problems  Mood changes
Sneezing  Shortness of breath  Hives  Fatigue
Itchy eyes  Tight chest  Rashes  Mental dullness
Post nasal drip  Exercise problems  Severe acne  Nausea
Ear problems  Phlegm or mucus  Abdominal cramps  Bloating

How long have you had these symptoms?
0-1 years  1-5 years  5-10 years  10+ years

What time of the year do you have these symptoms?
Jan  Feb  March  April  May  June  July  Aug  Sept  Oct  Nov  Dec
All the time__________________________  Cannot predict ___________________________
Do you have good months? _______________  If so, which? ___________________________

What else do you know about your allergy symptoms?
Are you aware of anything you are allergic to? __________________________________________
What do you think you might be allergic to? ____________________________________________
Are you exposed to chemicals? Dust? ___________________________________________________
Do you have pets / animals? __________________________________________________________
Are you allergic to any medication? ____________________________________________________
Do you smoke? ___________  If yes, how often? _________  How many years? _______________
Have you ever had allergy tests? _________  If yes: Skin test? _________  Blood Test? _________
Have you ever had allergy shots? _________  If so, when? ________________________________
Do your symptoms interfere with your:
Are your symptoms worse in the AM or PM? ____________________________________________

Form courtesy of Hitachi Chemical Diagnostics, Inc.