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:

Sleep? ____ Play? ____ Work? ____ Comfort? ____ Other? _____

Are your symptoms worse in the AM or PM? _____