ALLERGY HISTORY FORM

Patient's Name:_____ DOB: _____ Date: _____

Address: _____ Phone #: _____

What are your main allergy symptoms and concerns? _____

_____

Do you have any of these symptoms? (Please check all that apply)

□ Nasal congestion	□ Swollen lips or tongue	□ Coughing	□ Ear pressure
□ Sneezing	□ Scratchy throat	□ Shortness of Breath	□ Blocked ears
□ Runny nose	□ Itchy throat	□ Wheezing	□ Headaches
□ Hay fever	□ Post nasal drainage	□ Asthma	□ Heart burn
□ Sinus infections	□ Throat mucus/phlegm	□ Itchy skin	□ GERD (acid reflux)
□ Itchy eyes	□ Throat clearing	□ Hives	□ Stomach bloating
□ Swollen eyes	□ Throat tightness	□ Skin rashes	□ Abdominal cramping
□ Burning eyes	□ Swallowing difficulty	□ Eczema	□ Diarrhea
□ Mouth ulcers	□ Hoarseness	□ Itchy ears	

Are your allergy symptoms:
Year round? Yes____ No____
Seasonal? Yes____ No____ If yes, which months?_____

Are your symptoms mostly indoors, outdoors, or both? _____

Any reactions around cats? _____ dogs? _____ other animals?_____

What medications have you tried for your allergy symptoms? _____

_____

List all medications and supplements are you taking at the present time?

_____

Have you had allergy skin or blood testing? Yes____ No____ If yes, when? _____

What were the results?_____

Previous treatment with allergy shots? Yes___ No___
Previous treatment with allergy drops? Yes___ No ___

List any FOOD allergies and reactions experienced:

_____

_____

List any DRUG allergies and reactions experienced:

_____

List any CHEMICAL sensitivities and reactions experienced:_____

_____

Are you a smoker? Yes____ No____ If yes, how much? _____

Any family members with allergies? Yes____ No____ Any with asthma? Yes____ No____

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