Allergy History Form (page 1 of 2)

ALLERGY HISTORY

Patient Name: ____________________________________ Date: _______/_______/_________

Physician: ____

Check Conditions Affecting Symptoms

1. During which months do symptoms occur?

☐ All months

☐ January ☐ April ☐ July ☐ October

☐ February ☐ May ☐ August ☐ November

☐ March ☐ June ☐ September ☐ December

2. Are symptoms worse?

☐ Morning ☐ Afternoon ☐ Evening ☐ Night

☐ At home ☐ At work/school ☐ Other, location:__________________________

3. Are symptoms:

☐ Constant ☐ Erratic ☐ Rare

4. Do symptoms interfere with your activities?

☐ Not at all ☐ A little ☐ Moderately ☐ All the time

5. Family History:

☐ Asthma ☐ Eczema ☐ Sinus problems ☐ Migraine

☐ Hayfever ☐ ulcer ☐ Nervous disorder ☐ Colitis

☐ Other:____

6. Your medical conditions:

☐ High blood pressure ☐ Heart disease ☐ Asthma ☐ Bronchitis

☐ Bee sting allergy ☐ Thyroid disease ☐ Emphysema ☐ Diabetes

☐ Hormonal difficulty ☐ Stomach or intestinal problems/disease

☐ Drug allergy, specify:____

☐ Food allergy, specify:____

7. Do any of the following cause of make your symptoms worse?

☐ Milk/ milk products ☐ Fruit or juices ☐ Vegetables ☐ Eggs/egg products

☐ Beer ☐ Wine ☐ Wheat Products ☐ Liquors

☐ Nuts/beans/seeds ☐ Cheese ☐ Meat ☐ Mushrooms

☐ Vinegar ☐ Chicken ☐ Poultry ☐ Fish

☐ Other:______________________ ☐ Other:__________________________

☐ Other:______________________ ☐ Other:__________________________

MONTROSE FAMILY PRACTICE

8. Are your symptoms made worse by:

☐ Wind	☐ Smoke	☐ Barns/Hay	☐ High pollution day
☐ Damp areas	☐ Soap	☐ Powder	☐ Mowing lawns
☐ Insecticides	☐ Dust	☐ Paint fumes	☐ Perfumes
☐ Cosmetics	☐ Newspapers	☐ Wool	☐ House plants
☐ Weather change	☐ Wet weather	☐ Dry weather	☐ Hot day
☐ Cold day	☐ Air-conditioning	☐ Travel/Vacations	

☐ Indoors, explain: ____

☐ Outdoors, explain: ____

9. Do you have pets or are you exposed to other animals?

☐ Cats ☐ Dogs ☐ Other, list: ________________________

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PREVIOUS ALLERGY TREATMENT

1. Have you ever been treated with allergy shots?

☐ Yes ☐ No

If yes, what were you treated for?

☐ Grass pollens	☐ Molds	☐ Weed pollens	☐ Dust
☐ Tree pollens	☐ Animals		

2. Did the allergy shots help you?

☐ Yes ☐ No ☐ Don’t know

3. What years were the shots taken?

_____________ to _______________

OTHER INFORMATION

Please note below any other information you would like to add

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