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ALLERGY ASTHMA SPECIALISTS, PA
ALLERGY HISTORY

Patient to complete:

Today's date _____ Patient Name _____ Age _____ Race _____

Family Doctor _____ Referring Doctor _____

Reason for visit (chief complaint) 1. _____ For how long _____
2. _____ For how long _____
3. _____ For how long _____

MEDICAL HISTORY: (Symptom review) Do you have the following symptoms?

General: Frequent colds Fatigue tiredness Irritability Difficulty sleeping
 other severe medical problems? _____

Nose

Runny Itchy Stuffy Excessive sneezing
 Triggers:
 Snoring Mucus color: Clear/ Yellow/ Green
 Recurrent sinus infections
 No sense of smell No sense of taste
 Mouth breathing

Throat

Sore Scratchy
 Hoarseness
 Clearing throat?
 Post nasal drainage
 Recurrent infections/Strep.?
 Throat swelling/closing
 Itchy

Chest

Short of Breath
 Cough
 Mucus White Yellow Green
 Chest tightness
 Wheeze

Eyes

Watery Red
 Itchy Sore
 Dry
 Circles under eyes
 Eyelid swelling

Ears

Decreased hearing
 Fullness/popping
 Frequent infection
 History of ear tubes
 Itchy

Headache

Facial pain. Sinus pain
 Frequency _____ / week/month
 Location of pain _____

Abdominal

Nausea/ Vomiting
 Stomach upset
 Bloating/Gas
 Heartburn

Skin

Generalized rash Welts Itchy
 Eczema since _____
 Rash from
 Insect bite food
 Drug reaction other _____

PATTERN: Is the hay fever symptoms present all year on and off all year spring summer fall
 winter around dust/vacuuming mowing lawn/fresh cut grass cigarette smoke wood burning smoke
 around animals season change other _____

ASTHMA: Is your asthma triggered by Exercise Cold weather Infections Laughing
 Emotions/crying Night time GE reflux disease Cigarette smoke Smoke from wood burning?

ABSENTEISM: Days of school/work missed in last year because of these problems _____