

**ALLERGY ASTHMA SPECIALISTS, P.A.**  
**ALLERGY HISTORY**

**PATIENTS TO COMPLETE THIS FORM PRIOR TO OFFICE VISIT**

Date of office visit: \_\_\_\_\_ Patient's Name \_\_\_\_\_ Age \_\_\_\_\_ Race \_\_\_\_\_

Primary Care Doctor: \_\_\_\_\_ Phone # \_\_\_\_\_ Referring Doctor \_\_\_\_\_  
(First and last name)

**Symptoms for which you want to see Allergy Asthma Specialists:**

1. \_\_\_\_\_ Length (duration) of symptoms \_\_\_\_\_
2. \_\_\_\_\_ Length (duration) of symptoms \_\_\_\_\_
3. \_\_\_\_\_ Length (duration) of symptoms \_\_\_\_\_

**MEDICAL HISTORY:** Please put a cross (X) in the box provided if you suffer from any of the symptoms noted in the past 12 months

**General:**  Frequent colds  Fatigue  Tiredness  Irritable  Difficulty sleeping

**Nasal symptoms:**  Runny  Itchy  Stuffy  Sneezing  Dry For how long? \_\_\_\_\_ **Symptoms present:**  All year  
 On and off  Spring  Summer  Fall  Around dust/vacuuming  Animals  Freshly cut grass/mowing lawn  Cigarette smoke  
 Wood burning smoke  Season change  other \_\_\_\_\_ **Mucus color:**  Clear  Yellow  Green  Bloody  
 Frequent sinus infections. How many in past 12 months \_\_\_\_\_  Decreased sense of smell  Decrease sense of taste  
 Mouth breather  Snoring

**Eyes Symptoms**

Itchy  Watery  Red  Dry  Sore  Dark circles under the eyes  Eyelid swelling

**Ear symptoms**

Decreased hearing  Hearing test \_\_\_\_\_  Fullness/clogged  Popping  Frequent infections  Drainage  Itchy  Dry  
 History of ear tubes  Number of sets \_\_\_\_\_

**Throat symptoms**

Sore  Scratchy  Itchy  Hoarseness  Bad breath  Throat clearing  Post nasal drainage  Recurrent infections  
 Strep throat  Lump in the throat

**Headaches**

Facial pain  Sinus pain  Frequency \_\_\_\_\_ week / month.  Location of pain \_\_\_\_\_  Light sensitivity  Noise sensitivity  History of migraine headaches

**Skin symptoms**

Rash: date started? \_\_\_\_\_  Welts  Itchy  Dry  Scaly  Eczema, age at which it started \_\_\_\_\_  Rash caused by (list them) \_\_\_\_\_  Insect bite  Food  Drug reaction \_\_\_\_\_  Other \_\_\_\_\_

**Abdomen/Stomach**

Nausea  Vomiting  Stomach upset  Epigastric discomfort  Bloating  Gas  Heartburn (food or liquid to throat area)

**Lungs or Chest symptoms**

Cough  Dry  Productive **Mucus color:**  White  Yellow  Green  Blood tinged  Chest tightness  Short of breath

**Wheezing with:**  Breathing in  Breathing out  Exercise  Laying down

**Symptoms increases with:**  Cold weather  Infections  Laughing  Emotions/crying  Nighttime  Cigarette smoke

Wood burning smoke  Other \_\_\_\_\_

**ABSENTEISM:** Number of days missed from school or work in last 12 months because of the above problems \_\_\_\_\_