ALLERGY HISTORY

Name_____Date _____

Occupation _____

DOB _____

1. Check symptoms you have frequently.

____Itchy nose	____Itching eyes	____Sore throats
____Stuffy nose	____Watery eyes	____Cough
____Runny nose	____Itching throat	____Wheezing
____Sneezing	____Ear infections	____Headaches
____Post nasal drip	____Fluid in ears	____Eczema, rashes
____Loss of smell		

2. When did you first notice symptoms? _____

3. Would you say your symptoms are ____Slight ____Moderate ____Severe

4. Are your Symptoms ____Constant ____Erratic ____ Seasonal

5. When do you have symptoms? ____ Winter ____Spring _____Summer ___Fall

6. Are your symptoms worse around ..... ?

____Animals ____Foods ____Scents or Odors

7. Do you use medication for your allergy symptoms? if yes please write what you are using.

_____

8. Animals in the home: ____cat ____dog ____bird

9. Do you smoke? ____ yes _____ No

10. Previous head or neck surgeries?

11. Do any of your blood relatives have allergies? ____Yes ____No

12. Do you have asthma? _____yes _____No

13. Have you had any previous allergy testing?_____When?_____Results_____