BLUE RIDGE
EAR, NOSE, THROAT
& PLASTIC SURGERY

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ALLERGY HISTORY FORM

Date:_____

Patient's Name:_____ Sex:_____ Age:_____

Street:_____City:_____ State:_____ Zip:_____

Home Phone: ( )_____ Work Phone: ( )_____

Patient: Your answers to the following questions will help determine the cause of your allergy symptoms. Please check (✓) each question as accurately as possible.

Describe what symptoms bother you most:

_____

_____

When did these symptoms begin?

_____

Do you have symptoms, or is your trouble worse in:

- ☐ Spring
- ☐ Summer
- ☐ Fall
- ☐ Winter
- ☐ Year-round

List any allergy medications that work well for you:_____

_____

List any medications taken regularly:

_____

_____

List any drugs you have had reactions to:

_____

_____

_____

	YES	NO
Have trouble with your skin?		
Eczema		
Hives		
Other		

	YES	NO
Have trouble with your ears?		
Itching		
Popping/Fullness		
Hearing Loss		
Fluid		
Infection/Pain		
Dizziness		

	YES	NO
Have trouble with your throat?		
Itching throat/mouth		
Frequently sore		
Frequent throat clearing		

	YES	NO
Have trouble with your eyes?		
Redness		
Itching		
Tearing		
Puffiness		
Dark Circles		

	YES	NO
Have trouble with your nose?		
Clear drainage		
Colored thick drainage		
Itching/rubbing		
Sniffles		
Sneezing		
Stuffiness		
Postnasal Drip		
Mouth breathing/snoring		

	YES	NO
Have trouble with your chest?		
Cough		
What kind?		
Deep productive		
Constant		
Dry/tight		
Asthma?		
Wheezing with colds/dust		
pollen/animals		
Wheeze or cough with exercise		
Frequent bronchitis/pneumonia		

	YES	NO
Do you get headaches?		
Moderate		
Severe		
Present most of the time		
Present occasionally		
Interfering with life or job		

	YES	NO
Do you have unusual fatigue?		
Do you have fungal problems?		
(skin, athletes foot, vaginitis)		
Do you get sick frequently?		

	YES	NO
Do any family members have allergies?		

	YES	NO
Have you been tested before?		
When?		
Treatment?		
How long?		

Which of these cause you symptoms or make you worse?	YES	NO
Indoors		
Outdoors		
Home		
Workplace		
Morning		
Evening		
Weather Change		
Wet Weather		
Cold Weather		
Windy Day		
Humid/Hot Day		
Air Conditioning		
Damp Areas		
In Barns, Hay		
Mowing Lawn		
Dusty Environment		
House Cleaning		
High Air Pollution		
Animals		
Smoke		
Insecticides/Mothballs		
Chemicals/Cleaning Products		
Perfumes/Colognes/Powder		
Newspapers		
Hairdresser/Barber		
Other		

Do you live in: (circle) House/Trailer/Apartment	YES	NO
In the city / country		
Is your home new?		
Older than 20 years?		
Wet or damp basement?		
Live near water?		
Lots of houseplants?		
Carpet in bedroom?		
Feather pillow/comforter?		
Do you use in the bedroom: (circle) Curtains/shades/blinds		
Type of Bed?		
Regular mattress		
Waterbed		
Bunk bed		
How old is your mattress? _____		
Use a fan in your bedroom?		
Sleep with the windows open?		

Is your heating system:(circle) Gas/Wood/Electric/Oil	YES	NO
Do you use space heaters?		

Do you use air conditioning:	YES	NO
At work		
At home		
In bedroom		
In car		

Do you have pets in your home?	YES	NO
List:		
Outside mostly?		

Smokers in your home?	YES	NO
Do you smoke?		
Cigarettes #_____PPD		
Years Smoked?_____		
Stopped smoking in (year)_____		

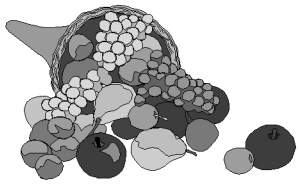
What is your occupation? _____
_____

Are any materials used in your job that affect your condition? _____	YES	NO

At work, are your symptoms:	YES	NO
Better		
Worse		
The Same		

Do you have trouble with your digestive system?	YES	NO
Hearburn/reflux		
Indigestion		
Nausea/Vomiting		
Bloating		
Bad Breath		
Diarrhea		
Excess Gas		

Do you have any significant reactions to insect bites/stings?	YES	NO
Type of reaction_____ _____		



Any seasonal food you overindulge in?(ex. strawberries) _____ _____	YES	NO

Is there family history of food allergy or intolerance?_____ _____	YES	NO

Are there any foods that cause or aggravate your symptoms?	YES	NO
List:		
Food_____Symptom_____		
Food_____Symptom_____		
Food_____Symptom_____		
Food_____Symptom_____		

Is there anything else about your problem you think may be important? _____ _____ _____ _____