ALLERGY AND ASTHMA SPECIALISTS OF SOUTH FLORIDA
ALLERGY HISTORY FORM

PATIENT'S NAME _____ **COMPUTER #** _____ **BIRTHDATE** _____ **APPOINTMENT DATE** _____

INSTRUCTIONS

REFERRING PHYSICIAN **(if any):** _____

Please answer the following questions as completely and as accurately as possible. The information you give will be very important in learning more about your allergy and how to control it.
Note: If you are filling this out for infant or child, remember that he or she is the patient and not you. Also, in the family history, the relatives specified are the patient's relatives.

BRIEFLY DESCRIBE REASON FOR ALLERGY VISIT.

_____

_____

For Physician Only *(Leave Blank)*

HAVE YOU EVER HAD THE FOLLOWING CONDITIONS?

YES		NO	Check each item)		Severity			Months of Year Affected
Present Problem	Past Problem			Age of Onset	Mild	Moderate	Severe	
☐	☐	☐	Hay fever (itching of nose, sneezing, stuffy nose, running nose)		☐	☐	☐	
☐	☐	☐	Asthma (wheezing)		☐	☐	☐	
☐	☐	☐	Other Breathing Problems - Shortness of Breath		☐	☐	☐	
☐	☐	☐	Hives or Swelling (urticaria-angioedema)		☐	☐	☐	
☐	☐	☐	Sinus Trouble - Frequent Colds		☐	☐	☐	
☐	☐	☐	Eczema or other rashes (Poison Oak, Etc.)		☐	☐	☐	
☐	☐	☐	Food Allergies		☐	☐	☐	
☐	☐	☐	Arthritic Diseases		☐	☐	☐	
☐	☐	☐	Immune Defect (frequent or recurrent infections)		☐	☐	☐	SEE BELOW IF YES
☐	☐	☐	Drug Allergy (Penicillin, Sulfa Aspirin, other)		☐	☐	☐	
☐	☐	☐	Bee Sting or Insect Hypersensitivity (large swelling, hives, shock)		☐	☐	☐	

If yes to DRUG ALLERGY
Date of reaction(s) _____
_____
_____

I reacted to the following medication (check)
☐ Penicillin ☐ Sulfa ☐ Aspirin ☐ Other (Specify) _____

I had the following reaction (Check):
☐ Swelling ☐ Hives ☐ Other (Specify)
☐ Seizures ☐ Wheezing _____
☐ Shock ☐ Rash

If yes to BEESTING
Date of stings(s) _____
_____
_____

I reacted to the following (check)
☐ Honey Bee ☐ Hornet ☐ Other (Specify)
☐ Yellow Jacket ☐ Wasp _____

I had the following reaction (check):
☐ Local Swelling ☐ Seizure ☐ Shock
☐ Hives ☐ Faintness ☐ Other (Specify)
☐ Wheezing ☐ Rash _____

FOR PHYSICIAN *(LEAVE BLANK)*

SYMPTOMS

(If this does not apply to your case, please go on to the next section.)

Please answer the following: Have you ever had any of the following symptoms? Indicate after the number of days, whether the symptoms were Mild, Moderate or Severe

	How many days in the last seven?	Mild Moderate Severe	How many days in an average week in Dec.?	Mild Moderate Severe	How many days in an average week in June?	Mild Moderate Severe
Sneezing		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
Nasal Congestion		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
or Running Nose		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
Itching Nose		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
Itching Eyes		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
Coughing		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
Wheezing		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
Coughing or Wheezing with Exercise		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
Headaches		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐
Post Nasal Drip		☐ ☐ ☐		☐ ☐ ☐		☐ ☐ ☐

GEOGRAPHIC HISTORY

Please list your last several residences *(City & State only)* with your most recent first and last effect on symptoms.

Residence *(City, State only)* **Effect on Symptoms - i.e. better, worse, etc.**

1. (Present) _____
2. _____
3. _____
4. _____
5. _____

For each item below, check the proper box whether condition is made worse, condition is improved, or unchanged. If item does not apply to you, check the box at right.

	Condition Made Worse	Condition Improved	No Change	Does not apply
Mowing lawn, walking on grass or playing in grass	☐	☐	☐	☐
Raking leaves	☐	☐	☐	☐
Other outdoor activities	☐	☐	☐	☐
High winds, or riding in auto with windows open	☐	☐	☐	☐
Sweeping, dusting, using vacuum cleaner	☐	☐	☐	☐
Moldy or mildewed areas or articles	☐	☐	☐	☐
Contact with or nearness to any animals *(Specify)* _____	☐	☐	☐	☐
Use of household cleaning agents, laundry soaps or detergents, etc. *(Specify)* _____	☐	☐	☐	☐
Use of paint, varnish, etc. *(Specify type)* _____	☐	☐	☐	☐
Strong odors *(Specify)* _____	☐	☐	☐	☐
Air conditioning either at home or places you visit	☐	☐	☐	☐
Trips away from home *(Specify area and time of year)* _____	☐	☐	☐	☐

	Condition Made Worse	Condition Improved	No Change	Does not apply
Following Rainfall	☐	☐	☐	☐
Smoking or smoke exposure	☐	☐	☐	☐
Use of hair sprays or tints, cosmetics, perfumes, deodorants, aftershave lotions, etc. *(Specify)* _____ _____	☐	☐	☐	☐
Taking of medication. Add Product name if you remember it. _____	☐	☐	☐	☐
Antihistamines or cold tablets	☐	☐	☐	☐
Nose drops or sprays _____	☐	☐	☐	☐
Asthma medicines or sprays _____	☐	☐	☐	☐
Aspirin _____	☐	☐	☐	☐
Others _____				
Bedtime	☐	☐	☐	☐
On awakening	☐	☐	☐	☐
Emotional upsets	☐	☐	☐	☐
Heavy physical exertion or exercise	☐	☐	☐	☐
Anything else you have noticed *(Specify)* _____	☐	☐	☐	☐

a. Have you ever noticed any symptoms *(rash, hay fever, asthma, stomachache, loose bowels, nausea)* after any of the following foods? *(Check appropriate boxes)*

☐Milk	☐Fish	☐Spices	☐Ginger	☐Alcohol
☐Eggs	☐ Shellfish	☐ Coffee	☐Fruits	☐Wine
☐Wheat	☐Peanuts	☐Mustard	☐Vegetables	☐Cheeses
☐Berries	☐Other Nuts	☐Chocolate	☐Meats	☐Other Foods
☐Melon	☐Tomatoes	☐Celery	☐Pastries	List _____

b. Explain _____

_____

c. Have you ever had poison ivy or poison oak?

☐Yes ☐No

Have you ever had allergy skin tests?

☐ Yes ☐ No If yes, Date _____ Doctor's Name _____

Doctor's Address _____

Do you recall the results of these tests (if so, list the positive tests)

_____

Did you ever receive allergy injections?

☐ Yes ☐ No If yes, Dates _____

Please list *all* medications that you are now taking *(if you don't know the name, give prescription number and druggist's phone or describe pill - color, shape)*

_____

_____

_____

What other medications have you taken in the past for allergies? _____

How frequently do you use a Nasal Spray? _____

FOR PHYSICIAN *(LEAVE BLANK)*

CC

PI

Hospitalizations

(Please List)	*Cause*	*Date*

Operations

(Please List)	*Cause*	*Date*

Immunizations

Polio	☐ Yes	☐ No	HIB	☐ Yes	☐ No	**FOR PHYSICIAN** *(LEAVE BLANK)*
Tetanus Booster	☐ Yes	☐ No	Chicken Pox	☐ Yes	☐ No	P.M.H
Measles or MMR	☐ Yes	☐ No	Hepatitis B	☐ Yes	☐ No	
DPT	☐ Yes	☐ No	Hepatitis A	☐ Yes	☐ No	
Pneumonia Vaccine	☐ Yes	☐ No	Influenza Vaccine	☐ Yes	☐ No	

Family History

Is there a history of allergy in your family? ***(i.e. parents, grandparents, brother or sisters, children, aunts or uncles)***

	Check Yes or No		**If yes, List RELATIONSHIP**
Allergy	☐ Yes	☐ No	_____
Hay fever	☐ Yes	☐ No	_____
Eczema	☐ Yes	☐ No	_____
Asthma	☐ Yes	☐ No	_____
Recurrent Pneumonia	☐ Yes	☐ No	_____
Hives	☐ Yes	☐ No	_____
Headaches	☐ Yes	☐ No	_____
Angioedema	☐ Yes	☐ No	_____
Swelling	☐ Yes	☐ No	_____
Immunodeficiency (reoccurring infections)	☐ Yes	☐ No	_____

FOR PHYSICIAN *(LEAVE BLANK)*

ENVIRONMENTAL HISTORY

What type of work do you do? _____

Are you exposed to anything at work that might aggravate your condition? _____

Have you missed any time from work or school because of your allergies? _____ **How much time?** _____

Do you have any other unusual exposures from hobbies, etc.? _____

Where do you live? ***(Area of city or in country)*** _____

How old is your house? _____ **Approximate number of indoor house plants** _____

Does your house have dampness, mold or mildew problems? _____

Type of heating *(forced hot air, hot water, steam, space heater, baseboard, electric ceiling).* _____

Do you have air conditioning?_____ **Do you have an air cleaner?**_____

TYPE OF CARPET (Wool, Nylon, etc., Jute Backing) AND PAD (Rubber, Ozite [Hair]) IN:

BEDROOM Carpet _____ Pad _____ **LIVING ROOM** Carpet _____ Pad _____

DEN Carpet _____ Pad _____ **DINING ROOM** Carpet _____ Pad _____

Number of beds in your bedroom: _____ **Does the bedroom or house tend to be dusty?** _____

Is your pillow stuffed with: ☐ Feather ☐ Foam ☐Dacron ☐Other *(Specify)* _____

Is your mattress: ☐ Foam ☐ Rubber ☐ Innerspring & Cotton ☐ Cotton ☐ Waterbed Other *(Specify)* _____

How old is your Pillow? _____ **Mattress?** _____

Do you have any stuffed furniture? ☐ Yes ☐ No **Feather comforters?** ☐ Yes ☐ No

Do you have pets? ☐ Yes ☐ No **Please list number** _____ **If yes, do they come inside?** ☐ Yes ☐ No

☐**Dogs** ☐**Cats** ☐**Birds** ☐**Other** ***(Specify)***) _____

Have you ever noted symptoms after exposure to them? Explain.

_____

_____

Social History

Have you used or been treated for:

Drug abuse? ☐ Yes ☐ No

Alcohol abuse? ☐ Yes ☐ No

Do you use alcohol? ☐ Yes ☐ No

Are you HIV Positive? ☐ Yes ☐ No

Have you ever smoked? ☐ Yes ☐ No

Do you presently smoke? ☐ Yes ☐ No

When did you quit? _____

What? *(Cigarette, cigars, pipe)* _____

For how many years have you smoked or did you smoke? _____

Average per day at your highest point _____

If you still smoke do you think that you could stop? _____

FOR PHYSICIAN *(LEAVE BLANK)*

_____

SIGNATURE - PHYSICIAN

ALLERGY AND ASTHMA SPECIALISTS OF SOUTH FLORIDA, LLC

REVIEW SYSTEMS

Name: _____

Please indicate below your history of or current problems with an "X" by YES. If you have never encountered a problem with any of the symptoms below, indicate with an "X" by NO.

GENERAL:

- ☐ YES ☐ NO Weight Gain
- ☐ YES ☐ NO Weight Loss
- ☐ YES ☐ NO Fever
- ☐ YES ☐ NO Chills
- ☐ YES ☐ NO Problems sleeping

HEAD, EYES, EARS, NOSE & THROAT:

- ☐ YES ☐ NO Change in vision
- ☐ YES ☐ NO Ear infections or drainage
- ☐ YES ☐ NO Sinus infections
- ☐ YES ☐ NO Problems swallowing
- ☐ YES ☐ NO Glaucoma
- ☐ YES ☐ NO Cataracts
- ☐ YES ☐ NO Impaired hearing

CARDIOVASCULAR:

- ☐ YES ☐ NO Chest pain
- ☐ YES ☐ NO Shortness breath w/ walking/lying
- ☐ YES ☐ NO Heart murmur
- ☐ YES ☐ NO Difficulty walking 2 blocks
- ☐ YES ☐ NO Palpitations
- ☐ YES ☐ NO Swelling of the feet
- ☐ YES ☐ NO Fainting

PULMONARY:

- ☐ YES ☐ NO Cough
- ☐ YES ☐ NO Shortness of breath
- ☐ YES ☐ NO Sputum production
- ☐ YES ☐ NO Emphysema/COPD
- ☐ YES ☐ NO Asthma
- ☐ YES ☐ NO Sleeping during the day
- ☐ YES ☐ NO Snoring

GASTROINTESTINAL:

- ☐ YES ☐ NO Heartburn
- ☐ YES ☐ NO Change of appetite
- ☐ YES ☐ NO Change in bowel habits
- ☐ YES ☐ NO Black, tarry stool
- ☐ YES ☐ NO Rectal bleeding

GENITOURINARY:

- ☐ YES ☐ NO Pain while urinating
- ☐ YES ☐ NO Burning while urinating
- ☐ YES ☐ NO Blood in urine
- ☐ YES ☐ NO Hesitancy in going
- ☐ YES ☐ NO Incontinence
- ☐ YES ☐ NO Night time urinating
  # times per night ___

MUSCULOSKELETAL:

- ☐ YES ☐ NO Arthritis
- ☐ YES ☐ NO Muscle weakness
- ☐ YES ☐ NO Frequent fractures
- ☐ YES ☐ NO Osteoporosis
- ☐ YES ☐ NO Joint stiffness

NEUROLOGICAL:

- ☐ YES ☐ NO Mini strokes
- ☐ YES ☐ NO Strokes
- ☐ YES ☐ NO Seizures
- ☐ YES ☐ NO Fainting spells
- ☐ YES ☐ NO Depression

PSYCHIATRIC:

- ☐ YES ☐ NO Depression
- ☐ YES ☐ NO Anxiety
- ☐ YES ☐ NO Other psychotic diagnosis

ENDOCRINE:

- ☐ YES ☐ NO Hypothyroidism
- ☐ YES ☐ NO Hyperthyroidism
- ☐ YES ☐ NO Diabetes
  ___ ☐ Insulin
  ___ ☐ Oral medications

SKIN:

- ☐ YES ☐ NO Rashes
- ☐ YES ☐ NO Jaundice
- ☐ YES ☐ NO Skin cancer
  Type:_____

OTHER:

_____