Allergy Health Assessment

Patient Name: _____ DOB: _____

Were you referred by another doctor: ❑ Yes ❑ No Doctors Name: _____

Please check all recurrent symptoms:

Nasal Symptoms	***Sinus Symptoms***	***Chest/Throat Symptoms***	***Skin Symptoms***
❑ Runny nose	❑ Post nasal drainage	❑ Wheezing	❑ Itching
❑ Nasal congestion	❑ Frequent throat clearing	❑ Chest tightness	❑ Eczema
❑ Sneezing	❑ Sinus pressure	❑ Shortness of breath	❑ Hives
❑ Itchy eyes	❑ Headache	❑ Cough	❑ Swelling
❑ Watery eyes	❑ Colored nasal mucous	❑ Wheezing with exercise	❑ Blisters
❑ Itchy nose	❑ Stuffy ears	❑ Difficulty breathing at night	❑ Contact allergy
❑ Itchy ears	❑ Frequent sinus infections	❑ Frequent pneumonia	❑ Other
❑ Itchy throat	❑ Bad breath	❑ Throat tightness	❑ _____
❑ Decreased taste or smell	❑ Snoring	❑ Hoarse voice	❑ _____

How long have you had these symptoms?

Nasal _____ Sinus _____ Chest _____ Skin _____

How often do the symptoms occur? (constant, daily, weekly, monthly, off-and-on)

Nasal _____ Sinus _____ Chest _____ Skin _____

Is there any seasonal variation in your symptoms and if so, when are they worse? ❑ Yes ❑ No

Nasal _____ Sinus _____ Chest _____ Skin _____

What medications have you tried for your allergy symptoms? Circle the ones that have helped.

_____

_____

Your Environment

What environmental triggers have made your symptoms worse?

❑ Mowed grass ❑ Windy weather ❑Dust ❑Spending time outdoors ❑Moldy places ❑Sweeping or dusting
❑ Cigarette smoke ❑Pollen ❑Insect sting ❑Exercise ❑Respiratory infections ❑Weather changes ❑Laughing
❑ Cold air ❑Nighttime ❑ Stressful events ❑Animals (specify) _____
❑ Perfumes, cosmetics, odors, etc. (specify) _____

How long have you lived in this area? _____ Where else have you lived? _____

Are you better or worse in this area? ❑ Better ❑ Worse

Do you have any pets? ❑ Yes ❑ No Please list: _____

Are symptoms worse when around your pet? ❑ Yes ❑ No Any previous pets in the home? ❑ Yes ❑ No

Any smokers in the home? ❑ Yes ❑ No Type of Home: ❑ Appartment/Condo ❑ House

Has your home had water or flood damage? ❑ Yes ❑ No

What kind of work do you do?_____ Are symptoms worse at work? ❑ Yes ❑ No

Have you travelled out of the country in the past year? ❑ Yes ❑ No Where?_____

Are there other households you visit frequently? ❑ Yes ❑ No Explain:_____

Family members with allergies/asthma? ❑ Mother ❑ Father ❑ Siblings

Please list all current medications including inhalers, over the counter medications, vitamins, and supplements:

_____

_____

_____

Any medications that you do not tolerate? ❑ Yes ❑ No If yes, list the medications and the reaction they caused:

_____

_____

_____

Any foods that you do not tolerate? ❑ Yes ❑ No If yes, list the foods and the reaction they caused:

_____

_____

Medical History (check all that apply)

❑ Cataracts ❑ High blood pressure ❑ Acid reflux ❑ Stroke ❑ Glaucoma ❑ Coronary artery disease ❑ Irritable bowel
❑ Migraine headaches ❑ Hearing loss ❑ Irregular heart beat ❑ Inflammatory bowel disease ❑ Seizure disorder
❑ Frequent nose bleeds ❑ Enlarged heart ❑ Diabetes ❑ Kidney disease ❑ Nasal polyps ❑ Lung disease ❑ Thyroid disorder
❑ Cancer ❑ Eartubes ❑ Sleep apnea ❑ Pituitary disorder ❑ Arthritis ❑ Osteoporosis ❑ Other _____

Previous Allergy Treatment

Other doctors seen for allergies: ❑ ENT ❑ Allergist ❑ Pulmonologist ❑ Dermatologist ❑ Gastroenterologist

Have you had nasal or sinus surgery? ❑ Yes ❑ No When and what were the results?_____

Have you been treated in urgent care or ER with asthma? ❑ Yes ❑ No Last Visit Date?_____

Have you had allergy tests? ❑ Yes ❑ No When and where?_____

Have you had allergy shots? ❑ Yes ❑ No When and where?_____

Social History

Do you now or have you ever smoked? ❑ Yes ❑ No How much & how long?_____

Is there anything else you would like to share regarding your allergies?

_____

_____

_____

If you could fix one thing about your allergies, what would it be?

_____

_____

_____