

## PATIENT HISTORY

Patient \_\_\_\_\_ Age \_\_\_\_\_ Sex  M  F

Physician \_\_\_\_\_

### FAMILY HISTORY *(Indicate members of your family who have had an allergic condition)*

- 1  mother      3  brother      5  grandparent  
 2  father      4  sister       mother's    father's

### PATIENT SYMPTOMS *(Indicate from the list below your major symptoms)*

#### GENERAL BODY

- 6  hives  
 7  rashes  
 8  aches  
 9  fever  
 10  tension  
 11  fatigue

#### DIGESTIVE TRACT

- 12  indigestion  
 13  diarrhea  
 14  abdominal pain  
 15  mucus in bowels  
 16  gas

#### HEAD

- 17  itchy eyes  
 18  watery eyes  
 19  puffy eyes  
 20  conjunctivitis  
 21  itchy eyes  
 22  popping in ears  
 23  runny nose  
 24  itchy nose  
 25  sneezing  
 26  congested nose  
 27  headache

#### THROAT/CHEST

- 28  coughing  
 29  wheezing  
 30  congested chest  
 31  shortness of breath  
 32  sore throat  
 33  itchy throat

### FREQUENCY/TIME AND DURATION OF SYMPTOMS *(Check the appropriate response below)*

34  sporadic (at various times of the year but with no pattern)

35  persistent (throughout the year)

36  seasonal (indicate the prominent months below)

- 37  Jan      38  Feb      39  Mar      40  Apr      41  May      42  Jun  
 43  July      44  Aug      45  Sep      46  Oct      47  Nov      48  Dec

#### DURATION

- 49  minutes  
 50  hours  
 51  days

#### TIME OF DAY    TIME OF DAY (con't)

- 52  morning      54  evening  
 53  afternoon      55  after meals

### SURROUNDINGS *(Indicate where/when symptoms occur below)*

#### OUTDOORS

- 56  after mowing lawn  
 57  in damp areas  
 58  while driving  
 59  while taking walks  
 60  while exercising  
 61  near burning leaves  
 62  near farms/barns

#### INDOORS

- 63  in basement/crawl space  
 64  after dusting/vacuuming  
 65  at school  
 66  at work *(if checked indicate occupation)* \_\_\_\_\_  
 67  after exercising

#### INDOORS (con't)

- 68  in bedroom  
 69  in kitchen  
 70  in attic

### TYPE/LOCATION OF HOME

- 71  single family
- 72  apartment/condominium
- 73  mobile home
- 74  in city
- 75  in suburbs
- 76  in heavily wooded area
- 77  in farming area

### HEATING SYSTEM

- 78  forced air
- 79  electric
- 80  oil
- 81  coal
- 82  radiant

### COOLING SYSTEM

- 83  air conditioner
- 84  oscillating fan(s)
- 85  ceiling fan(s)

### BEDROOM *(Indicate which items below are found in your bedroom)*

- |  |  |  |
|--|--|--|
| 86 <input type="checkbox"/> carpet               | 95 <input type="checkbox"/> books                                  |  |
| 87 <input type="checkbox"/> vinyl or wood floors | 96 <input type="checkbox"/> stuffed animals                        |  |
| 88 <input type="checkbox"/> drapes               | 97 <input type="checkbox"/> fans (ceiling or oscillating)          |  |
| 89 <input type="checkbox"/> vertical blinds      | 98 <input type="checkbox"/> air conditioner (if checked see below) |  |
| 90 <input type="checkbox"/> venetian blinds      | 99 <input type="checkbox"/> central                                |  |
| 91 <input type="checkbox"/> dehumidifier         | 100 <input type="checkbox"/> individual unit                       |  |
| 92 <input type="checkbox"/> cotton pillow        | 101 <input type="checkbox"/> cotton mattress                       |  |
| 93 <input type="checkbox"/> feather pillow       | 102 <input type="checkbox"/> feather mattress                      |  |
| 94 <input type="checkbox"/> foam rubber pillow   | 103 <input type="checkbox"/> foam rubber mattress                  | 104 <input type="checkbox"/> waterbed mattress |

### PETS

- 105  own pet(s) If checked, indicate the pet(s) below
- 106  visit home/farm that has pets. If checked, indicate the pet(s) below
 

|                                    |                                      |   |
|------------------------------------|--------------------------------------|---|
| 107 <input type="checkbox"/> cat   | 110 <input type="checkbox"/> bird    | 113 <input type="checkbox"/> other (list) |
| 108 <input type="checkbox"/> dog   | 111 <input type="checkbox"/> hamster | _____                                     |
| 109 <input type="checkbox"/> horse | 112 <input type="checkbox"/> rabbit  |   |

### INSECT BITES

- |     | YES                      | NO                       |  |
|-----|--------------------------|--------------------------|--|
| 114 | <input type="checkbox"/> | <input type="checkbox"/> | Have you ever had a severe reaction to insect bites?         |
| 115 | <input type="checkbox"/> | <input type="checkbox"/> | Have you been stung by an insect within the last six months? |

#### IF YOU CHECKED YES TO EITHER QUESTION ABOVE, INDICATE THE INSECT:

- |  |                                       |   |
|--|---------------------------------------|---|
| 116 <input type="checkbox"/> wasp          | 120 <input type="checkbox"/> tick     | 124 <input type="checkbox"/> ant          |
| 117 <input type="checkbox"/> hornet        | 121 <input type="checkbox"/> flea     | 125 <input type="checkbox"/> other (list) |
| 118 <input type="checkbox"/> yellow jacket | 122 <input type="checkbox"/> mosquito | _____                                     |
| 119 <input type="checkbox"/> honey bee     | 123 <input type="checkbox"/> spider   |   |

### MEDICATIONS *(Check any medications that you are presently taking)*

- |  |  |
|--|--|
| 126 <input type="checkbox"/> aspirin         | 131 <input type="checkbox"/> vitamins          |
| 127 <input type="checkbox"/> corticosteroids | 132 <input type="checkbox"/> nose drops/sprays |
| 128 <input type="checkbox"/> laxatives       | 133 <input type="checkbox"/> hormones          |
| 129 <input type="checkbox"/> sedatives       | 134 <input type="checkbox"/> other (list)      |
| 130 <input type="checkbox"/> birth control   | _____  |

- |     | YES                      | NO                       |  |
|-----|--------------------------|--------------------------|--|
| 135 | <input type="checkbox"/> | <input type="checkbox"/> | Are you or do you think you are allergic to any drugs? If yes, list below. |
|     |                          |                          | _____  |

**CONTACTANTS** (Indicate any substance below that may cause your symptoms or make them worse)

- |   |  |  |
|---|--|--|
| 136 <input type="checkbox"/> laundry soap   | 139 <input type="checkbox"/> shampoo         | 142 <input type="checkbox"/> cosmetics                 |
| 137 <input type="checkbox"/> dish detergent | 140 <input type="checkbox"/> cotton          | 143 <input type="checkbox"/> newspapers/magazine print |
| 138 <input type="checkbox"/> hand soap      | 141 <input type="checkbox"/> perfume/cologne | 144 <input type="checkbox"/> wool                      |

**DIETARY INFORMATION** (Indicate how often you eat the following foods)

|   | <u>DAILY</u>             | <u>WEEKLY</u>            | <u>RARELY</u>            | <u>NEVER</u>             |                                      | <u>DAILY</u>             | <u>WEEKLY</u>            | <u>RARELY</u>            | <u>NEVER</u>             |
|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 145 <input type="checkbox"/> milk         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 154 <input type="checkbox"/> beef    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 146 <input type="checkbox"/> eggs         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 155 <input type="checkbox"/> tuna    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 147 <input type="checkbox"/> wheat(bread) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 156 <input type="checkbox"/> codfish | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 148 <input type="checkbox"/> corn         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 157 <input type="checkbox"/> rice    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 149 <input type="checkbox"/> chocolate    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 158 <input type="checkbox"/> cereals | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 150 <input type="checkbox"/> peanuts      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 159 <input type="checkbox"/> potato  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 151 <input type="checkbox"/> orange       | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 160 <input type="checkbox"/> peas    | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 152 <input type="checkbox"/> soybean      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | 161 <input type="checkbox"/> beans   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 153 <input type="checkbox"/> pork         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |                                      |                          |                          |                          |                          |

162  List foods below that you think give you trouble:

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**MISCELLANEOUS** (Please answer the following questions)

- |     | <u>YES</u>               | <u>NO</u>  |
|-----|--------------------------|--|
| 163 | <input type="checkbox"/> | <input type="checkbox"/> Do you smoke?   |
| 164 | <input type="checkbox"/> | <input type="checkbox"/> Does anyone else in your household smoke?                             |
| 165 | <input type="checkbox"/> | <input type="checkbox"/> Are you exposed to unusual fumes at work or home? If yes, list below: |
- 

- |     |                          |  |
|-----|--------------------------|--|
| 166 | <input type="checkbox"/> | <input type="checkbox"/> Are you presently under any unusual form of stress?   |
| 167 | <input type="checkbox"/> | <input type="checkbox"/> Have you ever been treated for allergies before? If yes indicate type of treatment:   |
| 168 | <input type="checkbox"/> | <input type="checkbox"/> antihistamines      169 <input type="checkbox"/> corticosteroids      170 <input type="checkbox"/> immunotherapy (allergy injections) |

**EFFECTIVENESS OF TREATMENT**

- 171  poor      172  fair      173  good