

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:

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