ALLERGY HISTORY QUESTIONNAIRE

CARL THORNBLADE, MD

MEDICATION INSTRUCTIONS*:* ***If you have chronic hives, DO NOT stop antihistamines.*** Benadryl and other store brand antihistamines and decongestants must be stopped at least three days prior to skin testing. Antihistamines that need to be stopped for 7 days prior to testing are XYZAL, ZYRTEC, CLARITIN, CLARINEX, and ALLEGRA. If you have concerns about stopping any of your medications, please feel free to contact our office at (406)728-6472 and we will be happy to address any questions or concerns.

Please complete this questionnaire and bring it with you to your appointment. If the question does not apply to you or the patient please fill in “N/A”

Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age:\_\_\_\_\_\_\_\_\_ Birth date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parents Name (if patient is a minor):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Referring Physician:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. When was the last time you took an antihistamine? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of antihistamine: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. List of current medications (prescription and over the counter medications)

Name of Drug Dosage (10mg, 2 puffs, etc) How often taken (daily, as needed, etc)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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1. List any medications including antibiotics that you are allergic to or are intolerant to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Reason for Evaluation**

1. Please summarize briefly, what are your ***MAIN*** concerns (this is the most important question.):

2. What symptoms do you feel may be due to an allergy? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Age symptoms began? \_\_\_\_\_\_\_

1. **If patient wheezes, complete the following:**

1. With what symptoms does the wheezing problem begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. List the symptoms which then appear in order of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ occurrence:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. At what age did the wheezing begin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Has it improved? \_\_\_\_\_\_\_\_\_\_ Worsened? \_\_\_\_\_\_\_\_To what do you attribute this?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. When do the symptoms seem worse? All Year \_\_\_\_\_ Spring\_\_\_\_\_\_ Summer\_\_\_\_\_\_\_ Fall\_\_\_\_\_\_ Winter\_\_\_\_\_\_\_

6. Wheezing episodes occur \_\_\_\_\_\_\_ days per week during wheezing periods.

7. When does the wheezing usually occur? Morning \_\_\_\_\_\_\_\_\_\_\_ Afternoon \_\_\_\_\_\_\_\_\_\_ Evening \_\_\_\_\_\_\_\_\_\_

8. How long does the wheezing period last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

9. How often are the severe wheezing episodes? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ How long do the severe episodes last? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

10. Check the items which apply: Occasional wheezing \_\_\_\_\_ frequent wheezing \_\_\_\_\_\_ Constant wheezing \_\_\_\_\_\_\_

 Cough leading to wheezing \_\_\_\_\_\_ Fever with wheezing \_\_\_\_\_\_ wheezing with exertion \_\_\_\_\_\_

 Chest pain with wheezing \_\_\_\_\_\_\_

11. What medications have been used to control the wheezing and how effective is each? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

12. Did any medications cause any problems?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

13. Has any of the following been given to control the wheezing? Adrenalin \_\_\_\_\_\_\_\_ Cortisone or cortisone-like drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

14. Has the severity of an attack requires hospitalizations? No \_\_\_ Yes\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Where? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Nose**

1. Check the items which apply to nasal symptoms: Itching of nose or mouth \_\_\_\_\_ Nasal congestion \_\_\_\_\_ Clear nasal discharge\_\_\_\_\_\_ Colored nasal discharge \_\_\_\_\_\_\_\_ Fever with symptoms \_\_\_\_\_\_ Mouth breathing \_\_\_\_\_\_\_ Constant clearing of the throat \_\_\_\_\_\_ Sneezing \_\_\_\_\_\_ Bad Breath \_\_\_\_\_\_ Post nasal drip \_\_\_\_\_\_\_ Loss of smell \_\_\_\_\_ Nasal

 Polyps \_\_\_\_\_ Snoring \_\_\_\_\_\_ Sinus infections \_\_\_\_\_\_

2. At what age did these symptoms start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. When do the symptoms seem worse? All year \_\_\_\_\_\_ Spring \_\_\_\_\_ Summer \_\_\_\_\_ Fall \_\_\_\_ Winter \_\_\_\_\_\_\_

4. What medications have been used to control these symptoms and how effective is each? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Infections**

1. How many “colds” occur per year? \_\_\_\_\_\_\_\_\_\_\_ With wheezing? \_\_\_\_\_\_\_\_\_\_

2. How often does tonsillitis occur each year? \_\_\_\_\_\_\_ With wheezing? \_\_\_\_\_\_ Has patient had tonsillectomy? (yr) \_\_\_\_\_ Adenoidectomy? (yr)\_\_\_\_\_\_\_\_

3. Have there been episodes of Croup?\_\_\_\_ Bronchiolitis ?\_\_\_\_\_ Bronchitis?\_\_\_\_ Pneumonia ?\_\_\_\_Chest infections (date of last) \_\_\_\_\_\_\_\_\_\_\_\_

4. What antibiotics have been used to treat infections? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Headaches**

 1. Seldom\_\_\_\_\_\_\_\_\_\_\_\_\_ Occasionally \_\_\_\_\_\_\_\_Frequent\_\_\_\_\_\_\_\_\_\_\_\_

 2. Contributing factors? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Eye Complaints**

 1. Check symptoms that apply to you or the patient: Frequent itching \_\_\_\_\_\_\_ Frequent redness and or tearing \_\_\_\_\_\_

 Swelling of eye lids\_\_\_\_\_\_\_\_ Discharge from eyes \_\_\_\_\_\_\_ Sensitivity to light \_\_\_\_\_ Blurring of vision \_\_\_\_\_

 Burning sensation \_\_\_\_\_\_

 2. How often have these symptoms been a problem within the past year? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Ear Complaints**

 1. Check symptoms that apply to patient: Frequent earaches \_\_\_\_\_\_ Loss of hearing \_\_\_\_\_\_\_ Ear infections\_\_\_\_\_\_\_\_\_

 Dizziness\_\_\_\_\_\_ Discharge from ears\_\_\_\_\_\_\_\_

1. **Skin**

 1. Check symptoms that apply to patient: Eczema \_\_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_\_ Due to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Recurrent Rash \_\_\_\_\_ Hives \_\_\_\_ When? \_\_\_\_\_\_\_\_\_\_ Due to what? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Cold water hives or swelling \_\_\_\_

 Frequent skin infections (impetigo) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Dry or itchy skin? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Foods**

 1. Check any of the following that foods cause: Itching of lips or mouth \_\_\_\_\_\_\_ Itching of the skin \_\_\_\_\_ Hives \_\_\_\_\_\_\_\_\_\_

 Eczema \_\_\_\_\_ Rash \_\_\_\_\_ Headaches \_\_\_\_\_\_ Runny Nose \_\_\_\_\_\_ Nausea/vomiting \_\_\_\_\_ Wheezing \_\_\_\_\_\_

 Stomach Cramps \_\_\_\_\_\_ Diarrhea \_\_\_\_\_\_ Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Have any foods been eliminated from the diet? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. Did this change the severity of symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Is there a large intake of any particular food or beverage? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Precipitating factors of coughing, wheezing, nasal congestion, or sneezing**

 1. Check the items or situations that will cause any of the above symptoms to start or become worse:

\_\_\_\_Outdoors

\_\_\_\_Wet weather

\_\_\_\_Dry clear weather \_\_\_\_Change from clear to rainy \_\_\_\_Change from rainy to clear \_\_\_\_Sudden change in temp

\_\_\_\_Onset of cold weather

\_\_\_\_Change in humidity

\_\_\_\_Sudden chilling

\_\_\_\_Cold feet

\_\_\_\_Exertion

\_\_\_\_Fatigue

\_\_\_\_Laughing

\_\_\_\_Coughing

\_\_\_\_Emotional upset

\_\_\_\_Child discipline \_\_\_\_Home/indoors

\_\_\_\_Cleaning house

\_\_\_\_Contact with old furniture \_\_\_\_Attic/basement

\_\_\_\_Air conditioning

\_\_\_\_Contact with dogs or cats \_\_\_\_Contact with other animals \_\_\_\_Contact with feathers/wool \_\_\_\_Newly mowed grass

\_\_\_\_While on vacation

\_\_\_\_Seashore

\_\_\_\_Boat/airplane ride \_\_\_\_School/work/recreation

\_\_\_\_Being in the woods/mountains \_\_\_\_Car ride

\_\_\_\_Road dust

\_\_\_\_Cosmetics/perfume

\_\_\_\_Hairspray

\_\_\_\_Hair shampoos/rinses \_\_\_\_Hand/facial lotions

\_\_\_\_Body/facial powders \_\_\_\_Toothpaste/tooth powder \_\_\_\_Aspirin

\_\_\_\_Laundry soap powder

\_\_\_\_Flour dust

\_\_\_\_Insect dust/sprays

\_\_\_\_Fertilizers

\_\_\_\_Smoke or odors

\_\_\_\_Old leaves

\_\_\_\_Flowers

\_\_\_\_Other

\_\_\_\_Same everywhere

\_\_\_\_January

\_\_\_\_February

\_\_\_\_March

\_\_\_\_April

\_\_\_\_May

\_\_\_\_June

\_\_\_\_July

\_\_\_\_August

\_\_\_\_September

\_\_\_\_October

\_\_\_\_November

\_\_\_\_December

 2. Does anything from the list above (or anything else) cause improvement or worsening of symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**N)** **Problems the symptoms create for the patient:**

 1. Is there limitation of work? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Play? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Due to what symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. How many work/school days were missed during the past year due to this problem? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Have there been any long periods of freedom from symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. To what do you attribute this? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 6. Is there any place where the patient is symptoms free? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Residence when onset of symptoms occurred**

 1. State \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of resident \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Symptoms were: Seasonal \_\_\_\_\_\_\_\_\_\_\_ Year round \_\_\_\_\_\_\_\_\_\_\_\_ How severe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Previous allergy evaluations**

 1. Place where evaluated before? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. What were the results? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. Have allergy injections been received in the past? No\_\_\_\_ Yes \_\_\_\_ Give the start and stop dates of desensitization \_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_

 4. What was the composition of the allergy injections? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. Was there any improvement after having the allergy injections of a period of time? \_\_\_\_No \_\_\_\_ Yes

 6. Other studies done: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Allergic Reactions**

 1. What type of reaction when stung by a bee or wasp? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. What medication did you take? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3.Did you have to go the hospital?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Personal Medical History**

 1. List any other medical conditions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Does the patient have a heart condition or heart arrhythmia? (please specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. Check immunizations that have been completed: DPT series\_\_\_\_\_\_\_\_\_\_ Polio series \_\_\_\_\_\_\_ MMR \_\_\_\_\_\_ Hepatitis B series\_\_\_\_ Varicella \_\_\_\_\_\_\_ Hib series\_\_\_\_\_ Flu shot \_\_\_\_ Date of last Flu Shot?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Pneumovax\_\_\_\_\_\_\_ Date of last pneumovax\_\_\_\_\_\_\_\_\_\_\_\_

1. **Family History**

 Father Mother Brothers Sisters

 1. Age \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 2. Hay Fever \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. Asthma \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Eczema \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. Hives \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 6. Sinus Trouble \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 7. Heart Condition \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 8. Does any member of the family have a chronic illness? (specify)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 9. List any other medical problems you feel may be of importance.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 10. Is there any family member deceased?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cause?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 11. Does any illness seem to occur on either side of the family? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. **Environmental History (where patient lives and what he/she is exposed to)**

 1. Residence: Check which applies to your home Urban\_\_\_ Rural\_\_\_ Farm\_\_\_ Older house\_\_\_\_Newer house\_\_\_ Apartment\_\_\_

 2. Does the home have an attic? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Basement? (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 3. Is the home near a factory? (describe)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Farm? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Fields or wooded areas? (describe) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 4. Type of trees in your yard and neighborhood?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 5. Type of grass, flowers, or shrubs in the yard? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 6. Check which applies to the residence’s heating system: Central \_\_\_\_ Hot water \_\_\_\_\_ Electric \_\_\_\_\_ Gas \_\_\_\_\_ Wood \_\_\_\_\_

 7. Check which applies to the residence’s cooling system: None \_\_\_\_ Central AC \_\_\_\_ Window unit AC \_\_\_ Swamp cooler \_\_\_\_\_

 8. What kind of pets are in/out of the home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 9. What kind of house plants are in the home? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 10. Does anyone smoke in the home or car? Yes\_\_\_\_\_\_ No\_\_\_\_\_\_\_\_ Specify\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 11. Is there any place in the home where the patient’s symptoms are worse?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 12. Check the following that pertain to the patient’s bedroom: Heat or cooling vents\_\_\_\_ Overstuffed furniture \_\_\_\_

 Stuffed toys \_\_\_\_ Cosmetics/ powders/ hairspray \_\_\_\_ scented products (e.g. candles, potpourri) \_\_\_\_ out of season clothes in

 Closet \_\_\_\_ airtight covers for pillows or mattress \_\_\_\_\_

 13. Check and describe type for any of the following items that are in the patient’s bedroom:

 Carpet/ rug pad: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Throw rugs: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Curtains: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Mattress: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Pillows: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 14. Number of beds in room: \_\_\_\_\_\_\_\_\_\_\_\_ Number of persons sleeping in room \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 15. Is there mold growing anywhere in the house (describe)?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 16. Is there anything in your house or yard/around residence that has not been mentioned that you think is significant in

 contributing to the patient’s symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 17. What changes have you implemented to the patient’s environment to improve his/her symptoms?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**U)** **Other Comments:**