Patient History Form

Name_____Date of Birth_____ Age _____☐ Male ☐Female

CHIEF COMPLAINT- List your most troublesome symptoms Date of Appointment _____

_____

WHEN SYMPTOMS OCCUR

When did your symptoms first begin?_____
Are symptoms worse in any season(s)?_____
Do you have symptoms all year?_____ When are your worst seasons? _____
Are symptoms absent in any seasons (or months)? _____
Do symptoms vary with the time of day? _____ If so, how? _____
Are symptoms better indoors? _____Outdoors? _____ In air conditioning? _____
Are symptoms worsening? _____ Improving? _____ Staying the same? _____
What medicines (prescription and OTC) have you tried for your symptoms? _____

REVIEW OF SYMPTOMS

Allergy/Immunologic	**No**	**Yes**	**Respiratory**	**No**	**Yes**	**Cardiovascular**	**No**	**Yes**	**Psychiatric**	**No**	**Yes**
Sneezing			Cough			Chest pain			Depression		
Runny nose			Shortness of breath			Irregular heart beat			Anxiety/panic attacks		
Stuffy nose			Wheezing			Rapid heart rate			Insomnia		
Post nasal drip			Discolored sputum			Ankle swelling			Marked mood swings		
Itchy nose			Other			Other			Other		
Itchy throat			**Constitutional**	**No**	**Yes**	**Neurological**	**No**	**Yes**	**Musculoskeletal**	**No**	**Yes**
Itchy/watery eyes			Fatigue			Numbness			Joint pains		
Redness of eyes			Fever			Weakness			Joint swelling		
Swelling of eyelids			Chills			Migraine headaches			Stiffness of joints		
Other			Weight loss			Memory loss			Muscle pains		
Ears, Nose, Mouth, Throat	**No**	**Yes**	Other			Other			Other		
Ringing of ears			**Skin**			**Gastrointestinal**	**No**	**Yes**	**Hematologic/Lymphatic**	**No**	**Yes**
Decreased hearing			Hives or welts	**No**	**Yes**	Abdominal pain			Easy bruising		
Earaches			Swelling of eyelids			Bloating			Anemia		
Clogged ears			Eczema			Vomiting			Bleeding disorder		
Nose bleeding			Itching			Diarrhea			Swelling of an extremity		
Sore throat			Other			Other			Other		
Hoarseness			**Eyes**	**No**	**Yes**	**Endocrine**	**No**	**Yes**	**Genitourinary**	**No**	**Yes**
Sinus infections			Blurred Vision			Excessive thirst			Blood in urine		
Other			Double vision			Excessive hunger			Incontinence		
			Eye pain			Heat intolerance			Difficulty urinating		
			Dry eyes			Cold intolerance			Excessive urination		
			Other			Other			Other		

CURRENT MEDICATIONS

NAME	DOSE	HOW OFTEN TAKEN	NAME	DOSE	HOW OFTEN TAKEN

DRUG ALLERGIES

List all known drug allergies and reactions_____

PAST MEDICAL AND SURGICAL HISTORY

List all medical illnesses you have had_____

_____

List all past surgical procedures_____

_____

PREVIOUS REACTIONS TO BEES, WASPS, HORNETS, YELLOW JACKETS

List what insect, type of reaction, and when? _____

FOOD ALLERGIES

List any known food allergies and reactions such as hives, generalized itching, rash, vomiting, abdominal cramps, diarrhea, wheezing, swelling, headaches, nasal symptoms, etc._____

_____

FAMILY HISTORY

	Hay Fever	Asthma	Eczema	Hives	Swelling Episodes	Sinus Problems	Penicillin Allergy
Father	_____	_____	_____	_____	_____	_____	_____
Mother	_____	_____	_____	_____	_____	_____	_____
Sister	_____	_____	_____	_____	_____	_____	_____
Brother	_____	_____	_____	_____	_____	_____	_____
Grandmother	_____	_____	_____	_____	_____	_____	_____
Grandfather	_____	_____	_____	_____	_____	_____	_____
Child	_____	_____	_____	_____	_____	_____	_____

Please list any other relatives who have any allergy symptoms (Aunt, Uncle, etc.)

_____

SOCIAL HISTORY

Smoking ☐ Never smoked ☐ Former smoker ☐ Current smoker _____pack(s) per day for _____years

Does anyone else smoke at home? ☐No ☐Yes At work? ☐No ☐Yes

Alcohol Use ☐ None ☐ Less than 7 drinks per week ☐ More than 7 drinks per week

Pets (List number and type of pets) _____

ENVIRONMENTAL ALLERGIC FACTORS

Check the following factors which appear to aggravate or precipitate your symptoms.

_____	House Dust	_____	Cats	_____	Fumes	_____	Flowers	_____	Dry Heat
_____	Molds	_____	Rabbits	_____	Insecticides	_____	Cut grass	_____	Exertion
_____	Trees	_____	Birds	_____	Perfumes	_____	Changes in weather	_____	Fatigue
_____	Grasses	_____	Gerbils	_____	Cosmetics	_____	Sudden temp change	_____	Newspapers
_____	Weeds	_____	Hamsters	_____	Soaps	_____	High humidity	_____	Aerosol sprays
_____	Feathers	_____	Horses	_____	Facial powders	_____	Change in location	_____	Alcohol
_____	Wool	_____	Other animals	_____	Toothpaste	_____	Pollution	_____	At work
_____	Dogs	_____	Smoke	_____	Shampoos	_____	Air conditioning	_____	At home

ENVIRONMENTAL SURVEY

Lived in present area for _____ years. Lived previously in _____

Have lived in present home for _____ years.

Present home is in _____ urban, _____suburban, _____ rural, or _____ farm area.

Home is a _____ house, _____ apartment, _____ condo, _____ mobile home, or _____ other.

Heating is _____ forced air, _____ radiator, _____ baseboard, or _____ other.

Air conditioning is _____ central, _____ window unit(s), or _____ bedroom only.

Humidifier: _____none, _____ central humidifier, _____ portable humidifier, _____ vaporizer

Air filter: _____ none, _____ electronic air filter, _____ electrostatic air filter, _____ HEPA filter

Type of flooring in _____ bedroom, _____ living room, _____ dining room, _____ family room (wall-to-wall carpet, area rugs, hardwood floor, tile, etc.)

Home has an _____ attic, _____ basement, _____ garage, _____ fireplace, _____ wood stove.

Basement is _____ finished, _____ unfinished.

House plants: ___ none, or types _____

Bedroom: _____ carpet type, _____ pillow type(s), _____ blanket type(s), _____ stuffed toys, _____ pets in bedroom, _____ over-stuffed furniture.

PREVIOUS ALLERGY EVALUATION

By whom (Name, address, and phone number) _____

_____

Date _____ Test results _____

Treatment Given_____ Duration_____