# 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** | **No** | **Yes** | **Gastrointestinal** | **No** | **Yes** | **Hematologic/Lymphatic** | **No** | **Yes** |
| Decreased hearing | ☐ | ☐ | Hives or welts | ☐ | ☐ | 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_____