Patient History-Allergy Diagnosis

Name____________________________________

Occupation______________________________

Phone________________________**DOB**_______

Medications:____________________________

Which of the following symptoms have you experienced?
Please circle all that apply.

Hay fever   Runny Nose   Stuffy Nose   Sinus Problems

Sneezing   Itchy Eyes   Post Nasal Drip   Ear Problems

Asthma   Cough   Cough(night only)   Wheezing

Shortness of Breath   Tight Chest   Exercise Symptoms

Phlegm or Mucus   Headache   Diarrhea   Hives   Fatigue   Eczema

Rashes   Severe Acne   Nausea

How long have you had these symptoms?
0-1 years   1-5 years   5-10 years   10+ years

Times of year your symptoms worsen?
Spring   Summer   Fall   Winter   No Change

Environmental exposure
Pets in home________________________

Plants in house yes/no

Smoke, how often?_______How many years?_______

Do your symptoms interfere with you're:
Sleep?_____ Play?____ Work?____ Comfort?____

Are your symptoms worse in AM or PM?

Are your symptoms worse indoors or outdoors?

Have you ever had allergy testing?   Yes or No

Sbc1/29/09