

Dusting/Cleaning Other: _____

All Current Medicines:

number of mg, tabs,
caps, or inhaler puffs

| | | |
|-------|-------|---------------------|
| _____ | _____ | _____ times per day |
| _____ | _____ | _____ times per day |
| _____ | _____ | _____ times per day |
| _____ | _____ | _____ times per day |
| _____ | _____ | _____ times per day |
| _____ | _____ | _____ times per day |
| _____ | _____ | _____ times per day |
| _____ | _____ | _____ times per day |

PHYSICIAN NOTES

Previous allergy or asthma medications (including OTC):

| | | |
|-------|---------------------------------|----------------------------------|
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> no help |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> no help |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> no help |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> no help |
| _____ | <input type="checkbox"/> helped | <input type="checkbox"/> no help |

Past Medical History:

Birth Weight: _____ Problems at Birth? YES / NO

Surgeries:

(Age or year)

| | | |
|-------|-----|-------|
| _____ | for | _____ |
| _____ | for | _____ |
| _____ | for | _____ |

Hospitalizations (other than surgery):

(Age or year)

| | | |
|-------|-----|-------|
| _____ | for | _____ |
| _____ | for | _____ |
| _____ | for | _____ |
| _____ | for | _____ |

Drug Allergies:

| | | |
|-------|--------|-------|
| _____ | caused | _____ |
| _____ | caused | _____ |

Immunization Adverse Reactions:

| | | |
|-------|--------|-------|
| _____ | caused | _____ |
| _____ | caused | _____ |

Past Allergy History: (use space at right if needed)

YES NO

Previous allergy testing (If 'yes' then answer the questions below)

Testing by Dr. _____ Year _____

Previous allergy shots

Currently on allergy injections every ___ weeks

Do You Have:

YES NO

Cats

Dogs

Birds

Other pets: _____

Feather pillow

Down comforter

YES NO

Cigarette smoke

Wood burning stove

Damp basement

Mold growth

Room air cleaner

Whole house air cleaner

Name of person filling out this history form (print): _____
Relationship if not the patient: _____

IF YOU ARE CONCERNED ABOUT HIVES OR FOOD ALLERGIES, PLEASE ANSWER THESE QUESTIONS:

HIVES:

PHYSICIAN NOTES

Do you have any other symptoms at the same time?

Wheezing? Y/N

Trouble swallowing? Y/N

Sensation of throat closing? Y/N

Review of Systems

History of low or high thyroid? Y/N

History of hepatitis? Y/N

History of lupus or rheumatoid arthritis? Y/N

Do you work around latex rubber products? Y/N

Do you frequently take Aspirin, Ibuprofen or NSAID's? Y/N

FOOD ALLERGY:

What are your symptoms?

Hives? Y/N

Anaphylaxis? Y/N

Wheezing? Y/N

Throat swelling or trouble swallowing? Y/N

Vomiting or abdominal pain? Y/N

Eczema? Y/N

Other symptoms? Specify _____

Do you know what food causes a reaction? Y/N

Specify: _____

How soon after eating this food do the symptoms appear?

How much of the food do you eat before the reaction occurs?

Have you ever required an ER visit or hospitalization for a food reaction? Y/N _____

Have you ever had testing for food allergies? Y/N